Title 24: Mental Health

Part 10: Record Guide for Mental Health, Intellectual and Developmental Disabilities, and Substance Use Disorders Community Providers

REPEAL

~~Department of Mental Health~~
~~Record Guide~~
~~For~~
~~Mental Health, Intellectual and Developmental Disabilities, and Substance Use Disorders Community Providers~~

~~2016 Revision~~

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~~Section A~~
~~General Information~~

~~2016 DMH Operational Standards Record Guide~~

~~Purpose~~

~~Documentation required in the Mississippi Department of Mental Health (DMH) Record Guide serves as one of the methods for planning and evaluating services and supports provided by agencies and providers certified by the DMH. The intent of the record system outlined in this guide is to help ensure compliance with the DMH Operational Standards.~~

~~The emphasis of this Record Guide is on guidance needed to satisfy any and all documentation requirements referenced in the DMH Operational Standards or otherwise needed to ensure documentation of all services provided by agencies certified by DMH. Because of the DMH mandatory data collection and reporting requirements, along with the increasing use of electronic record keeping that many providers are implementing, the need to maintain paper forms is declining. This guide seeks to describe the type and amount of documentation that is necessary and provide a sample of a format with all information needed to satisfy the DMH record keeping requirements.~~

~~**Additional information may be added and the appearance of the form may be changed by the local provider.**~~ ~~However, if required data or information is deleted in the process of modifying the form, it will no longer satisfy DMH Operational Standards for record keeping.~~

~~General Information~~

~~A single case record must be maintained for all individuals served by the agency/provider and must contain specific mandatory data and information. Additional data or information may be included to ensure that sufficient information is maintained to protect the privacy of all individuals receiving services. Two years of documentation must be maintained in the active record. All completed documentation should be present in the individual's record no later than the 10th day of the following month the service was delivered unless more stringent timelines are required by DMH.~~

~~The Record Guide is divided into sections that allow the user to identify those forms or data tools required for all individual records, those that are used when the circumstances of the individual receiving services dictates their use, those that are specific to an area of service, and those that are administrative documentation that is not maintained in an individual's record.~~

~~Each form has specific guidance that states the purpose of the form/data tool. Also included in the guidance are references to the DMH Operational Standards and specific information regarding the nature and purpose of all forms/data tools.~~

~~References to "days" in the Record Guide mean calendar days.~~

~~Any section or area of a form that is not applicable must contain a strikethrough line that clearly indicates the item was not overlooked or omitted and that it does not apply to the individual receiving services.~~

~~Signatory Authority~~

~~Signatures are necessary to verify that information has been correctly and thoroughly shared with individuals receiving services. Signatures are also necessary to create a legally binding document. Forms in the Record Guide require signatures necessary for proper authorization of a particular form. Each signature line provided is clearly marked as to who is expected to sign. All signature lines on all forms must either be signed or marked as “not applicable” if that is the correct response. For example, all of the signature lines provided may not be necessary to document the individuals who participated in development of the Individual Service Plan or the Periodic Staffing/Review of the Individual Service Plan.~~

~~Electronic signatures are allowed on any form in the Record Guide.~~

~~Signature of the Individual Receiving Services~~

~~The individual receiving services must sign for himself or herself unless one of the following conditions applies or is present:~~

1. ~~The individual is under 18 years of age.~~
2. ~~A legal representative has been appointed for the person by a court of competent jurisdiction.~~
3. ~~If a person cannot physically sign or is not mentally/cognitively able to understand the form, a parent or next of kin can sign if they indicate they are signing as such. Physical, mental or cognitive ability to sign and understand the form must be determined by a medical doctor or psychologist. Documentation must be maintained in the record.~~

~~Signature of Individual Authorized to Give Consent or Sign in Lieu of the Individual Receiving Services~~

~~If one of the conditions stated above applies and the person is unable to sign for himself or herself, the person who is authorized to give consent or sign in lieu of the individual must sign the form(s). If the individual is under 18 years of age, this authorized representative is the parent unless a court ordered (legal) guardian or a conservator has been appointed for the child/youth. If the individual receiving services, regardless of his/her age, has a court ordered (legal) guardian or a conservator, the guardian/conservator must sign all forms on behalf of the individual receiving services.~~ **~~In the case of a court ordered (legal) guardian/conservator, a copy of guardianship/conservatorship papers must be maintained in the record.~~**

~~The legal guardian or conservator of an individual receiving service(s) must review and sign the paperwork required in order for an individual to receive services.~~

~~Should the individual’s legal guardian or conservator choose to delegate his/her responsibility and signatory authority to another individual for the completion of daily paperwork (including delegating signature authority to the individual being served), DMH will accept the signature of that individual. The legal guardian or conservator must provide~~ **~~written documentation~~** ~~of such delegation and to whom the signatory authority is being delegated. This must be maintained in the individual’s record. Daily signature~~

~~authority cannot be delegated to the service provider. However, the legal guardian or conservator must continue to sign annual paperwork, such as the Consent for Services and Individual Service Plan.~~

~~Signature of Witness/Credential~~

~~In the case of some DMH documentation, a witness must sign in order to verify that the signature(s) are valid, particularly if a person is signing in lieu of the individual receiving services. Forms requiring the signature of a witness will have a signature line provided for the witness. This requirement will be reflected in the guidance for that particular form.~~

~~If an individual signs with a mark or an "X," the signature of a witness is required. If the form does not include a line for a witness, the witness will sign next to the mark or "X."~~

~~If the witness is an employee of the facility or program, he/she must include his/her credentials or position.~~

~~Billing~~

~~All questions concerning billing should reference the funding source. Questions concerning Medicaid billing should reference the Medicaid Guidelines issued by the Division of Medicaid, Office of the Governor.~~

~~Section B~~
~~Required For All Records~~

~~Face Sheet~~

~~Consent to Receive Services~~

~~Rights of Individuals Receiving Services~~

~~Acknowledgment of Grievance Procedure~~

~~Consent to Release/Obtain Information~~

~~Medication/Emergency Contact Information~~

~~Face Sheet~~

~~Purpose~~

~~The Face Sheet contains relevant data and/or personal information necessary to readily identify the individual receiving services. Information on the Face Sheet is used for routine service provision activities such as scheduling, billing, and reference.~~

~~Timeline~~

~~The Initial Face Sheet must be prepared at admission as part of the intake process. The Face Sheet must be updated whenever information or data changes and/or at least annually. When changes in information or data are made, or at the annual update, a new/corrected Face Sheet must be dated and placed in the individual record.~~

~~Face Sheet Information~~

~~Each DMH certified provider must maintain current and accurate data for submission of all reports and data as required by DMH. The Face Sheet can be generated as a report by the agency's database system once all the data has been entered into the agency's system. Depending on the specific data collection and reporting system that the agency uses, additional personal information may have to be added to complete the Face Sheet. The Face Sheet must contain all 42 data elements required in the DMH Manual of Uniform Data Standards.~~

~~The required elements of the Face Sheet are provided on the following page. Providers should reference the DMH Manual of Uniform Data Standards for applicable codes and should consult with the agency employee responsible for data submission. Providers can also contact DMH Division of Information Services for additional guidance, 601-359-1288.~~

~~Required Data Elements for Face Sheet~~

1. ~~Record transaction type (add, change, delete)~~
2. ~~Organization code~~
3. ~~Unique client ID within organization~~
4. ~~Client status~~
5. ~~Admission date (most recent) to organization~~
6. ~~Admission type (primary, collateral, unregister)~~
7. ~~Admission referral category~~
8. ~~Admission referral organization code (referrals to/from a DMH operated program only)~~
9. ~~Legal status of client at admission~~
10. ~~Client last name~~
11. ~~Client first name~~
12. ~~Client maiden name (if applicable)~~
13. ~~Social Security Number (unique client identifier)~~
14. ~~Birth date~~
15. ~~Age of client (calculated from birth date)~~
16. ~~Sex~~
17. ~~Race~~
18. ~~Hispanic origin~~
19. ~~Education level: last grade completed~~
20. ~~Marital status~~
21. ~~County of residence prior to admission~~
22. ~~Living arrangement~~
23. ~~Type of residence~~
24. ~~Employment status - Include place of employment if applicable.~~
25. ~~Primary source of household income~~
26. ~~Household annual income amount~~
27. ~~No. of persons in household dependent on income~~
28. ~~Is the individual pregnant?~~
29. ~~Eligibility for SSI/SSDI~~
30. ~~Eligibility for Medicaid~~
31. ~~Expected principle source of payment~~
32. ~~Veterans status~~
33. ~~Physical impairment (1 of 2)~~
34. ~~Physical impairment (2 of 2)~~
35. ~~Presenting problem (1 of 2)~~
36. ~~Presenting problem (2 of 2)~~
37. ~~Treatment category (MH, MR, SA, dual)~~
38. ~~Primary treatment category (if dual)~~
39. ~~Is client seriously mentally ill ?(Y/N)~~

~~**40.** Is client seriously emotionally disturbed child? (Y/N)~~
~~**41.** Medicaid number~~
~~**42.** State ID (generated by CDR upon 1^{st} submission)~~

~~Consent To Receive Services~~

~~Purpose~~

~~In addition to all rights of individuals receiving services, each individual must provide his/her consent to receive services from the agency.~~

~~Time Line~~

~~Individuals receiving services must be informed of and consent to services at the time of the admission and before services are provided.~~

~~Individuals must provide their consent for services at least annually, on or before the anniversary date of the current consent, as long as the individual continues to receive services.~~

~~For ID/DD Waiver Support Coordination Services, individuals must provide their consent for services at least annually, before the end of the person's certification period.~~

~~For IDD providers, individuals must provide their consent at the time the Activity Support Plan is developed and annually thereafter.~~

~~Consent to Receive Services~~

~~This section can be read by, or if necessary, read to the individual receiving services and/or a person who is legally authorized to act on his/her behalf. In either case, the Consent To Receive Services and the limits of confidentiality must be clearly explained to the individual receiving services and/or a person authorized to act on his/her behalf.~~

~~Signatures~~

~~If the individual receiving services is unable to sign and the form is being signed by a court ordered (legal) guardian/conservator, a copy of guardianship/conservatorship papers must be maintained in the record.~~

~~The Consent to Receive Services, Rights of Individuals Receiving Services and Acknowledgment of Grievance forms can be combined into one document as long as space is included in the document for signature or initials of the individual receiving services or legal guardian to acknowledge each separate action.~~

~~Consent To Receive Services~~

~~**Name**~~	
~~**ID Number**~~	
~~**Service(s)**~~	

~~The information which I have provided as a condition of receiving services is true and complete to the best of my knowledge. I consent to receive services as may be recommended by the professional staff. I understand the professional staff may discuss the services being provided to me, and that I may request the names of those involved. I further understand that my failure to comply with therapeutic recommendations of the professional staff may result in my being discharged.~~

~~I understand that I have the freedom of choice to receive services in a setting that is integrated in and supports full access to the greater community; and is a setting that facilitates individual choice regarding services and supports, and who provides them.~~

~~I understand that State and federal laws and regulations prohibit any entity receiving confidential information from redistributing the information to any other entity without the specific written consent of the person to whom it pertains or as otherwise permitted by law and regulations.~~

~~I understand that confidential information may be released without my consent when necessary for continued services; when release is necessary for the determination of eligibility for benefits, compliance with statutory reporting requirements, or other lawful purpose; if you communicate to the treating physician, psychologist, master social worker or licensed professional counselor an actual threat of physical violence against a clearly identified or reasonably identifiable potential victim or victims; in compliance with reporting requirements under state law of incidents of suspected child abuse or neglect, or by court order.~~

~~**Individual/Legal Representative Signature**~~	~~**Date**~~
~~**Staff Signature/Credentials**~~	~~**Date**~~

~~Rights of Individuals Receiving Services~~

~~Purpose~~

~~Each individual who receives services from a DMH certified agency or provider has legal, ethical, and privacy rights that must be protected. DMH certified agencies must maintain documentation showing each individual who receives services has been informed of these rights. This document also informs the individual receiving services of legal circumstances in which the provider will be required to release information concerning his/her treatment/services. After the individual receiving services has been informed of his/her rights, the individual is then offered the opportunity to consent to receive services.~~

~~Time Line~~

~~Individuals receiving services must be informed of his/her rights during the admission process and before services are provided.~~

~~Individuals must be informed of his/her rights at least annually, on or before the anniversary date of the current form, as long as the individual continues to receive services.~~

~~For ID/DD Waiver Support Coordination Services, individuals must be informed of their rights at least annually, before the end of the person's certification period.~~

~~For IDD providers, individuals must be informed of their rights at the time the Activity Support Plan is developed and annually thereafter.~~

~~Intake/Admission Date~~

~~The intake/admission date is the original date of intake/admission to the service. This date remains the same from year to year as long as the person is continuously enrolled in the service.~~

~~Rights~~

~~The rights can be read by, or if necessary, read to the individual receiving services and/or to a person who is legally authorized to act on his/her behalf. The rights must be clearly explained to the individual receiving services and/or a person authorized to act on his/her behalf. The individual must be offered a copy of the form to take with them. Signed documentation of receipt must be maintained in the record. Providers may omit #18-22 if those service types are not provided by the agency.~~

~~The Consent to Receive Services, Rights of Individuals Receiving Services and Acknowledgment of Grievance forms can be combined into one document as long as space is included in the document for signature or initials of the individual receiving services or legal guardian to acknowledge each separate action.~~

~~Rights of Individuals Receiving Services~~

~~Name~~ ______________________

~~ID Number~~ ______________________

~~I,~~ ______________________ ~~began receiving services provided by~~ ______________________

~~Name~~ ~~Name of Provider~~

~~on~~ ______________ ~~and have been informed of the following:~~

~~Intake/Admission Date~~

1. ~~My options within the program and of other services available~~
2. ~~The program's rules and regulations~~
3. ~~The responsibility of the program to refer me to another agency if this program becomes unable to serve me or meet my needs~~
4. ~~My right to refuse treatment and withdraw from this program at any time~~
5. ~~My right not to be subjected to corporal punishment or unethical treatment which includes my right to be free from any forms of abuse, neglect, exploitation or harassment and my right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff~~
6. ~~My right to voice my opinions, recommendations and to file a written grievance which will result in program review and response without retribution~~
7. ~~My right to be informed of and provided a copy of the local procedure for filing a grievance at the local level or with the DMH Office of Consumer Support~~
8. ~~My right to privacy and confidentiality in respect to facility visitors in day programs, residential treatment programs, and community living programs as much as physically possible~~
9. ~~My right regarding the program's nondiscrimination policies related to HIV infection and AIDS~~
10. ~~My right to be treated with consideration, respect, and full recognition of my dignity and individual worth~~
11. ~~My right to have reasonable access to the clergy and advocates and have access to legal counsel at all times~~
12. ~~My right to review my records, except when restricted by law~~
13. ~~My right to fully participate in and receive a copy of my Individual Service Plan/Plan of Services and Supports or Activity Plan. This includes: 1) having the right to make decisions regarding my care, being involved in my care planning and treatment and being able to request or refuse treatment; 2) having access to information in my case records within a reasonable time frame (5 days) or having the reason for not having access communicated to me; and, 3) having the right to be informed about any hazardous side effects of medication prescribed by staff medical personnel~~
14. ~~My right to retain all Constitutional rights, except when restricted by due process and resulting court order~~
15. ~~My right to have a family member or representative of my choice notified should I be admitted to a hospital~~
16. ~~My right to receive care in a safe setting~~
17. ~~My right to confidentiality regarding my personal information involving receiving services as well as the compilation, storage, and dissemination of my individual case records in accordance with standards outlined by the Department of Mental Health and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if applicable~~

~~Additionally, rights for individuals in supervised and residential treatment arrangements:~~

18. ~~My right to be provided a means of communicating with persons outside the program~~
19. ~~My right to have visitation by close relatives and/or significant others during reasonable hours unless clinically contraindicated and documented in my case record~~
20. ~~My right to be provided with safe storage, accessibility, and accountability of my funds~~
21. ~~My right to be permitted to send/receive mail without hindrance unless clinically contraindicated and documented in my case record~~
22. ~~My right to be permitted to conduct private telephone conversations with family and friends, unless clinically contraindicated and documented in my case record~~

~~I have been informed of, understand, and have received a written copy of the above information.~~

~~Individual Receiving Services~~	~~Date~~	~~Legal Representative~~	~~Date~~
~~Staff/Credentials~~	~~Date~~		

~~Acknowledgment of Grievance Procedures~~

~~Purpose~~

~~The provider's grievance procedures must be provided to the individual and/or legal representative during the admission process. The information can be read by, or if necessary, read to the individual receiving services and/or a person who is legally authorized to act on his/her behalf.~~

~~Time Line~~

~~Individuals receiving services must be informed of and provided a copy of the provider's Grievance Procedures at the time of the admission and before services are provided. Each individual receiving services must be presented with the provider's Grievance Procedures when they are being asked to give his/her consent to receive services.~~

~~Individuals acknowledge receipt of the Grievance Procedures at least annually, on or before the anniversary date of the current acknowledgment, as long as the individual continues to receive services. A copy of the Grievance Procedures given to the individual receiving services should be attached and kept with the signed form.~~

~~For ID/DD Waiver Support Coordination Services, individuals must sign the acknowledgment at least annually, before the end of the person's certification period.~~

~~For IDD providers, individuals must sign the acknowledgment at the time the Activity Support Plan is developed and annually thereafter.~~

~~The Consent to Receive Services, Rights of Individuals Receiving Services and Acknowledgment of Grievance forms can be combined into one document as long as space is included in the document for signature or initials of the individual receiving services or legal guardian to acknowledge each separate action.~~

# ~~Acknowledgment of Grievance Procedures~~	~~**Name**~~ ________________________ ~~**ID Number**~~ ________________________

~~I have been informed of the policies and procedures for reporting a grievance concerning any treatment or service that I receive.~~

________________________	________________________
~~**Individual/Legal Representative Signature**~~	~~**Date**~~
________________________	________________________
~~**Staff Signature/Credentials**~~	~~**Date**~~

~~Consent to Release/Obtain Information~~

~~Purpose~~

~~Providers must have prior written authorization before information regarding an individual receiving service can be released. A fully executed Consent to Release/Obtain Information must be in place in order to legally exchange, release, or obtain information between individuals, agencies and/or providers. The original Consent to Release/Obtain Information form must always be maintained in the individual's case record.~~

~~Release/Obtain Information~~

~~Enter the name and address of the agency from which the action is required.~~

~~Complete the Release Information To when requesting a provider to send confidential information about an individual to another entity.~~

~~Complete the Obtain Information From section when confidential information regarding an individual receiving/requesting to receive services needs to be obtained from another entity.~~

~~The specific purpose for which the information is needed must be indicated. Staff must specify the exact reason for obtaining/releasing the information.~~

~~Extent/Nature of Information~~

~~The specific extent and/or nature of the information to be disclosed must be checked. If 'Other' is checked, the specific extent/nature of the disclosure must be described in detail. A generic authorization for the non-specific release of medical or other personal information is not sufficient for this purpose.~~

~~Date/Event/Condition~~

~~In order to clearly show the point in time when the Consent will expire, the following information must be provided: 1) the month, day, and year, or 2) an event, or; 3) a condition that will deem the Consent form expired; meaning no further action can be taken once the specific date/event/condition is satisfied. An example of an event or condition may be, "30 days after discharge or termination of services".~~

~~For children and youth receiving services in a school setting, a date period that covers a specific school year must be used.~~

~~The actions, conditions and limits of the consent must be clearly explained to the individual receiving services and/or to a person who is legally authorized to act on his/her behalf.~~

~~The provider must clearly explain the conditions under which confidential information may be released without consent. Confidential information may be released without consent when necessary for continued services; when release is necessary for the determination of eligibility for benefits, compliance with statutory reporting requirements, or other lawful purpose; if you communicate to the treating physician, psychologist, master social worker or licensed professional counselor an actual threat of physical violence against a clearly identified or reasonably identifiable potential victim or victims; in compliance with reporting requirements under state law of incidents of suspected child abuse or neglect or by court order.~~

~~**Witness**~~

~~The Consent to Release/Obtain Information requires the signature of a witness. If the witness is an employee of the program, he/she must include his/her credentials (if applicable). If the individual receiving services can only make their mark (for example "X"), place the mark in quotations and write out beside it, John Doe's Mark substituting individual's name. A second witness to the individual's signature is required in this case.~~

Consent to Release/Obtain Information	**Name** _ **ID Number** _ **Date** _

I hereby give my consent/permission for ______________________________

(Agency Name and Address)

☐ To release information to: ______________________________

(Agency/Person Name/Title and Address)

☐ To obtain information from: ______________________________

(Agency/Person Name/Title and Address)

For the specific purpose of:

☐ Treatment

☐ Coordination of Services

☐ Other ______________________________

The extent and nature of the information to be disclosed/obtained must be indicated (**check all that apply**):

☐ Evaluations	☐ Diagnosis/Prognosis/Recommendations
☐ Progress Notes	☐ Psychiatric Records
☐ Substance Abuse Records	☐ Admission/ Discharge Summary
☐ Contact Summaries	☐ Activity Support Plan
☐ Identifying Information	☐ Individual Service Plan/ Plan of Services & Supports
☐ Other ______________________________	

I understand that I may revoke this consent at any time except to the extent that action has been taken. I further understand that this consent will expire upon ______________________________

(Specific Date/Event/Condition)

and cannot be renewed without my consent. I understand that to revoke this authorization, Individual or Legal Representative must provide a written request and the revocation will not apply to action or information that has already been released/obtained in response to this authorization. Any information obtained as a result of this release is confidential. State and federal laws and regulations prohibit any entity receiving confidential information from redistributing the information to any other entity without the specific written consent of the person to whom it pertains or as otherwise permitted by law and regulations. I understand the information I authorize for release may include information related to history/diagnosis and/or treatment of HIV, AIDS, communicable or sexually transmitted diseases and alcohol/drug abuse or dependency.

I understand that confidential information may be released without my consent when necessary for continued services; when release is necessary for the determination of eligibility for benefits, compliance with statutory reporting requirements, or other lawful purpose; if you communicate to the treating physician, psychologist, master social worker or licensed professional counselor an actual threat of physical violence against a clearly identified or reasonably identifiable potential victim or victims; in compliance with reporting requirements under state law of incidents of suspected child abuse or neglect or by court order.

By signing below, I acknowledge receipt of a copy of the signed authorization

Individual Receiving Services	Date	Legal Representative	Date
Witness/Credentials	Date		

~~Medication/Emergency Contact Information~~

~~Purpose~~

~~Documentation of medications must be maintained while the individual is receiving services from a DMH certified agency or provider. The Medication/Emergency Contact Information is not to be used for the regular dispensing of medication. An important component is the documentation of all the individual's known allergic and/or adverse reactions. Emergency contact information must be completed to ensure immediate and appropriate response in the event of an emergency.~~

~~Timeline~~

~~The medications the individual is taking and the emergency contact information are recorded during the admission process. The information must be updated when medications are discontinued or added and at least annually.~~

~~Updates~~

~~The person entering updated information (new medications/changes to existing medications/discontinuation of a medication) must write the date the changes were made and sign the form in the designated space. The same form can be used until all spaces for medications are filled. At that time, a new form must be completed to ensure clarity. Any time the emergency contact information changes, a new form must be completed and placed in the individual's record.~~

~~Staff Signature/Date Initiated~~

~~Each medication entry must be signed by the person completing the form. If known, enter the date the individual began taking the medication. If this information is unavailable, signify such by entering "NK" in the "Date Initiated" column.~~

~~Current Medication~~

~~All sections must be addressed. ALL known and/or reported medications the individual is currently taking must be listed, regardless of type or purpose, including over-the-counter (OTC) medications the individual may be taking. The name of the medical professional prescribing each medication must be listed. All known or reported prescribed medications must be documented. Medication information regarding dosage and frequency must be listed exactly as prescribed. If there are no prescribed or OTC medications, the person completing the form must write "no prescription or OTC meds" and his/her initials.~~

~~Previous Medications/ Dietary Needs~~

~~Previously prescribed or taken medications listed; including any adverse reactions as reported by the individual; any special dietary needs.~~

~~Date Terminated/Changed/Staff Signature~~

~~If a medication dosage or frequency is changed, enter the date in the column. This space is also to be used if a medication is discontinued. The staff person entering the information must sign the form.~~

~~Allergies/ Adverse Reactions~~

~~Each of the individual's known allergies and his/her reactions to them must be documented. Include reactions if applicable. Allergies may include, but not be limited to, medications, insect bites, plants, foods, fragrances/aromas, or anything else that produces an allergic or adverse reaction.~~

~~Medication/Emergency Contact Information~~	~~Name~~ ____________________ ~~ID Number~~ ____________________

~~Name/Credentials of Staff Initially Completing the form:~~

~~Date Initially Completed:~~	

~~CURRENT MEDICATIONS~~

~~List ALL known and/or reported medications the individual is currently taking regardless of type or purpose to include over-the-counter (OTC) medications (use additional pages, if needed):~~

~~Staff Signature/ Credential~~	~~Date Initiated~~	~~Name of Medication~~	~~Prescribed by~~	~~Dosage/ Frequency~~	~~Date Terminated/ Changed~~	~~Staff Signature/ Credential~~

~~Known Allergies/Reactions~~~~:~~

~~PREVIOUS MEDICATIONS~~

~~Medication~~	~~Directions~~	~~Comments~~ ~~(to include adverse reactions if applicable)~~

~~**Special Dietary Needs** *(if applicable)*:~~

~~**Emergency Information:**~~

~~***In case of emergency (when parent/legal representative cannot be reached) contact:***~~

~~**Name:**~~

~~**Phone Number:**~~ ~~**(primary)**~~ ~~**(secondary)**~~

~~**Address:**~~

~~**Primary Doctor:**~~

~~**Doctor's Phone:**~~

~~**Doctor's Address:**~~

~~**Hospital Preference:**~~

~~**Insurance Carrier(s):**~~

~~**Policy Number(s):**~~

~~Section C~~
~~Required For All~~
~~Mental Health and~~
~~Substance Use Records~~

~~Initial Assessment~~

~~Trauma History~~

~~Individual Service Plan~~

~~Individual Crisis Support Plan~~

~~Recovery Support Plan~~

~~Periodic Staffing/ Review of the Individual Service Plan~~

~~Progress Note~~

~~Weekly Progress Note~~

~~Readmission Assessment Update~~

~~Substance Use Disorder Specific Assessment~~

~~Initial Assessment~~

~~Purpose~~

~~The Initial Assessment is used to document pertinent information that will be used as part of the process for determining what service or combination of services might best meet an individual's stated/presenting need(s). The information gathered is both historical as well as what is currently happening in an individual's life.~~

~~Responses of "No" or "Not Present", are acceptable. If an entire section does not apply to someone, the recorder can enter "Not Applicable." However, if the answer is "Yes" or "Present", then additional narrative and explanation is required.~~

~~Timeline~~

~~The Initial Assessment is part of the intake process and must be completed within the service specific timeline requirements.~~

~~Admission Date~~

~~Enter the date the individual was admitted to service(s).~~

~~Assessment Date~~

~~Enter the date the Initial Assessment was started.~~

~~Informant~~

~~If assessment information is provided by someone other than the individual receiving services, enter the person's relationship to the individual requesting services. A Consent to Release/ Obtain Information must be completed if applicable.~~

~~Guardianship Information~~

~~If individual has a legal guardian record name and contact information.~~

~~Confidentiality~~

~~Mark yes if limits of confidentiality are discussed with individual/guardian. If not, mark no with an explanation.~~

~~Description of Need~~

~~Record the reason(s) the individual gives as to why he/she is seeking services, current needs, goals etc. If substance use disorder is indicated in this section, a Substance Use Specific Assessment must be completed.~~

~~Social / Cultural~~

~~Complete social information, current living situation, and family history sections as applicable with information provided by the informant.~~

~~History~~

~~Complete the history section as applicable with information provided by informant.~~

~~The *developmental history section* should be completed for Children and Youth up to age 21 and all individuals with IDD.~~

~~The *education section* and *additional information section* should be completed for all Children and Youth up to age 21.~~

~~The *employment section* should be completed for adults not employed at the time of the assessment.~~

~~All items in the history sections must be completed. Responses of “No” or “Not Present”, are acceptable. If an entire section does not apply to someone, the recorder can enter “Not Applicable.” However, if the answer is “Yes” or “Present”, then additional narrative and explanation is required.~~

~~Medical History~~

~~Complete the additional medical information as applicable with information provided by informant.~~

~~All items in the history sections must be completed. Responses of “No” or “Not Present”, are acceptable. If an entire section does not apply to someone, the recorder can enter “Not Applicable.” However, if the answer is “Yes” or “Present”, then additional narrative and explanation is required.~~

~~Individual Mental Health History~~

~~Complete the outpatient mental health and psychiatric hospitalization/ residential treatment sections as applicable with information provided by informant.~~

~~All items in the history sections must be completed. Responses of “No” or “Not Present”, are acceptable. If an entire section does not apply to someone, the recorder can enter “Not Applicable.” However, if the answer is “Yes” or “Present”, then additional narrative and explanation is required.~~

~~Initial Behavioral Observation~~

~~Record observations for all areas listed. <u>All areas</u> must be evaluated. Comments must be included to further explain or clarify the specific observed behaviors.~~

~~Indication of Functional Limitation(s)~~

~~An assessment must be conducted and the results documented for the major life areas specified for each individual seeking admission to services.~~

~~The Child and Adolescent Functional Assessment Scale (CAFAS) is required for all children/youth receiving mental health services. The CAFAS must be completed within 30 days for all children/youth receiving mental health services or within timelines as required by service.~~

~~An approved functional assessment is required for all adults receiving mental health services. An approved functional assessment must be completed within 30 days for all adults receiving mental health services or within timelines as required by service. DMH will review and approve a functional assessment for use with the adult SMI population.~~

~~An approved functional assessment is required for all individuals receiving substance use disorder services. DMH will review and approve a functional assessment for use with the SUD population.~~

~~Summary/Recommendations~~

~~The person conducting the Initial Assessment must summarize the observations and findings to include an analysis of the individual's strengths and needs, both expressed and observed. Based on the results of the Initial Assessment, services must be recommended and offered to the individual. Referrals to other appropriate providers must also be offered to the individual. Observations, findings and recommendations should support a life of recovery related to the following dimensions:~~

~~Health- managing one's disease; making informed, healthy choices that support physical and emotional well-being~~

~~Home- having a stable and safe place to live~~

~~Community- having relationships and social networks that provide support, friendship, love and hope~~

~~Purpose- conducting meaningful daily activities to participate in society~~

~~Initial Diagnostic Impression~~

~~Give the written diagnostic impression and appropriate codes.~~

~~Staff Qualifications~~

~~The Initial Assessment must be completed by an individual with at least a Master's degree in mental health or intellectual/developmental disabilities, or a related field and who has either (1) a professional license or (2) a DMH credential as a Mental Health Therapist, Intellectual/Developmental Disabilities Therapist or Substance Abuse Therapist (as appropriate to the population being served).~~

~~For Alzheimer's Day Programs only, the program supervisor must complete the Initial Assessment. A copy of the individual's current history and physical, signed by an MD or Psychologist must be provided to confirm diagnosis.~~

Initial Assessment

Name: ______________________________

ID Number: ______________________________

Admission Date: ______________________________

Assessment Date: ______________________________

Time In: __________ Time Out: __________ Total Time:

Informant: ☐ Individual Receiving Services ☐ Other: Relationship to Individual ______________________

Does the person seeking services have an Outpatient Commitment Order? ☐ Yes ☐ No

GUARDIANSHIP INFORMATION

Name of Guardian / Custodian:	Guardianship Documentation Verified: ☐ Yes ☐ No
Guardian / Custodian Address:	Guardian / Custodian Phone Number:

Is the family involved with the Department of Human Services? ☐ Yes ☐ No

If yes, has a consent to release information been obtained? ☐ Yes ☐ No

If yes, please explain and indicate the name of the assigned case worker: ______________________

CONFIDENTIALITY

Were the limits of confidentiality reviewed with Individual and/or Guardian? ☐ Yes ☐ No

If NO, please explain.

DESCRIPTION OF NEED

What is your reason for seeking services today? What specific needs do you currently have?
(Include a description/perception of difficulties according to the individual seeking services and any applicable family members/legal guardian.)

Is the reason for seeking services today related to substance use? ☐ Yes ☐ No
If yes, the substance use specific assessment must also be completed.

What previous coping skills have been helpful in the past?

Thoughts of Suicide: ☐ Yes *(If yes, explain)* ☐ No

Attempts of Suicide: ☐ Yes *(If yes, explain)* ☐ No

~~**Thoughts of Homicide:** ☐ Yes *(If yes, explain)* ☐ No~~
~~*(Indicate the need for "duty to warn")*~~

~~**Acts of Self-Harm:** ☐ Yes *(If yes, explain)* ☐ No~~

~~SOCIAL / CULTURAL~~

~~**Identification of Support Systems:**~~
~~*(Address family relationships, interpersonal relationships, and community support systems)*~~

~~**Meaningful Activities, Cultural / Ethnic / Spiritual interests, Supports:**~~
~~*(Address hobbies, leisure activities, etc.)*~~

~~Living Situation~~

~~**What is your current living arrangement (strengths and concerns)? Who lives with you? What are your views on your current arrangement?**~~

~~**Needs Related to Living Situation**~~
~~(money management, benefits, living arrangements, clothing, personal care, child care, rent, other)~~

~~Developmental History~~

~~(Complete only for Children & Youth up to age 21 and everyone with ID/DD)~~

~~During pregnancy, did mother use alcohol or other drugs? ☐ Yes ☐ No~~

~~Describe any problems with the pregnancy or birth:~~

~~Were there any developmental issues? ☐ Yes ☐ No *(If yes, explain)*~~

~~Describe any childhood accidents or injuries:~~

~~**Education** (Children & Youth up to age 21)~~

~~Name of school:~~

~~Does child/youth receive Special Education Services?~~
~~☐ Yes *(If yes, complete release of information to obtain a copy of the current Individualized Education Plan (IEP))*~~
~~☐ No~~

~~***Additional Information*** (Children & Youth up to age 21)~~

~~Educational Issues/ Needs (grades, attendance, suspensions, expulsions)~~

~~**Employment *(adults only)***~~

~~Are you employed? ☐ Yes ☐ No~~

~~If no, do you want to be employed?~~

~~Employment Barriers/ Related Needs?~~

~~**Current Legal Status**~~

~~Has the individual been involved with the legal system within the past twelve months?~~
~~☐ Yes ☐ No~~

~~Arrests: ☐ Yes ☐ No~~	~~If yes, indicate type and number of arrest(s):~~

~~Number of arrests in the past 30 days:~~

~~Pending Charges: ☐ Yes ☐ No~~	~~If yes, indicate type and number of pending charges:~~

~~Substance Use Related Legal Issues:~~

~~Is this person currently on parole and/or probation? ☐ Yes ☐ No~~
~~If applicable, indicate to whom reports should be submitted:~~ ____

~~**MEDICAL HISTORY**~~

~~Appetite Issues:~~

~~Sleep Issues:~~

~~Current or Chronic Diseases~~	~~☐ high blood pressure ☐ diabetes ☐ thyroid ☐ other~~ ______________________
~~Family History~~	~~☐ high blood pressure ☐ diabetes ☐ thyroid ☐ other~~ ______________________

~~Additional Medical History or Health and Safety Issues:~~

~~**Health-Related Needs**:~~

~~INDIVIDUAL MENTAL HEALTH HISTORY~~

~~Previous Assessment History~~

~~Have psychological, educational or functional assessments been completed in the last twelve months?~~
☐ ~~Yes~~ *~~(If yes, complete release of information to obtain a copy of the applicable assessment.)~~*

~~If yes, indicate type of assessment~~____

☐ ~~No~~

~~Previous or Current Diagnoses:~~

~~Mental Health Needs~~~~:~~

~~Family History of Psychiatric or Substance Use Disorder(s)~~ ☐ ~~Yes~~ ☐ ~~No~~
~~If yes, please describe.~~

~~Outpatient Behavioral Health Agency~~

☐ ~~None Reported~~

~~Treatment Agency~~	~~Services Received~~	~~Dates of Service~~	~~Has Consent to Release Information Been Requested?~~
			☐ ~~Yes~~ ☐ ~~No~~
			☐ ~~Yes~~ ☐ ~~No~~
			☐ ~~Yes~~ ☐ ~~No~~

~~Psychiatric Hospitalizations / Residential Treatment~~

☐ ~~None Reported~~

~~Treatments~~	~~Reason (suicidal, depressed, etc.)~~	~~Dates of Service~~	~~Has Consent to Release Information Been Requested?~~
			☐ ~~Yes~~ ☐ ~~No~~

			~~☐ Yes ☐ No~~
			~~☐ Yes ☐ No~~

~~Initial Observations~~

~~General Observations~~	~~Appearance:~~ ~~☐ Appropriate ☐ Disheveled ☐ Unclean ☐ Other~~ ______________________________
	~~Speech:~~ ~~☐ Appropriate ☐ Slow ☐ Mechanical ☐ Rapid ☐ Other~~ ______________________________
	~~Affect:~~ ~~☐ Appropriate ☐ Flat ☐ Labile ☐ Other~~ ______________________________
~~Delusions:~~	~~☐ N/A~~ ~~☐ Description:~~
~~Hallucinations:~~	~~☐ N/A~~ ~~☐ Description:~~
~~Mood~~	~~☐ Appropriate ☐ Manic ☐ Depressed ☐ Labile ☐ Irritable ☐ Other~~ ____________________
~~Orientation~~	~~☐ Person ☐ Place ☐ Time ☐ Situation ☐ Other~~______________________________

~~Indication Of Functional Limitation(s):~~

~~(Check Major Life Areas Affected)~~

	~~Basic living skills (eating, bathing, dressing, etc.)~~
	~~Instrumental living skills (maintain a household, managing money, getting around the community, taking prescribed medications, etc.)~~
	~~Social functioning (ability to function within the family, vocational or educational function, other social contexts, etc.)~~

~~SUMMARY / RECOMMENDATIONS~~

~~Health:~~

~~Home:~~

~~Community:~~

~~Purpose:~~

~~Other:~~

~~INITIAL DIAGNOSTIC IMPRESSION~~	
~~Codes:~~	~~Description:~~

~~SIGNATURES / CREDENTIALS~~			
~~X~~	~~Date:~~	~~X~~	~~Date:~~
~~X~~	~~Date:~~	~~X~~	~~Date:~~

~~Trauma History~~

~~Purpose~~

~~The Trauma History is a screening tool designed to determine whether or not an individual receiving services has experienced trauma in the past. This tool is not a standardized measure and there are no scoring guidelines. This assessment should be administered in an interview format that allows the clinician to explain questions in a developmentally appropriate manner to ensure the client understands what is being asked. The interview process also allows the clinician to observe nonverbal responses to questions that might indicate a trauma response such as anxiety, fear, avoidance, shame, etc.~~

~~General~~

~~The timeline for completion of the Trauma History is determined by the type of service or program the individual is entering.~~

~~All individuals receiving services must complete a trauma history questionnaire. Outpatient Services must complete the trauma history questionnaire within 30 days of admission; Day programs must complete the trauma history questionnaire within 30 days of admission. Primary Residential Services within 5 days of admission to the services. Crisis Stabilization Services must complete the trauma history questionnaire within 48 hours of admission. Results of trauma history questionnaire should be incorporated into ISP and subsequent services.~~

~~The Trauma History Assessment is not a tool for gathering information or details about the traumatic event. The clinician should maintain a neutral tone when asking each question. If the client indicates he/she has experienced an event, then the therapist only asks at what age the traumatic event(s) started and ended. If the client offers more information, the clinician captures that content but does not attempt to elicit more details than offered, challenge nor process the information shared.~~

~~If the client reports a positive trauma history, the clinician asks the client to identify the trauma that is most distressing at that time. The identified trauma is then incorporated into the Individual Service Plan and subsequent services and can be referred to when administering formal trauma assessments.~~

~~Trauma History~~

~~Name~~ ______________________

~~ID Number~~ ______________________

~~Date~~ ______________________

~~Time In:~~ ~~Time Out:~~ ~~Total:~~

~~Please indicate if any of the following have happened to you and how it may have affected you.~~

~~Have you ever served in the military, law enforcement or as a first responder?~~ ~~☐ Yes ☐ No~~

~~If yes, indicate the capacity in which you served.~~

~~Have you ever seen or been in a really bad accident?~~

~~Has someone close to you ever been so badly injured or sick that s/he almost died?~~

~~Has someone close to you ever died?~~

~~Have you ever been so sick that you or the doctor thought you might die?~~

~~Have you ever been unexpectedly separated from someone who you depend on for love or security for more than a few days?~~

~~Has someone close to you ever tried to kill or hurt him/herself?~~

~~Has someone ever physically hurt you or threatened to hurt you?~~

~~Trauma History~~

~~Name~~ ______________________

~~ID Number~~ ______________________

~~Have you ever been mugged or seen someone you care about get mugged?~~

~~Has anyone ever kidnapped you?~~

~~Have you ever been attacked by a dog or other animal?~~

~~Have you ever seen or heard people physically fighting or threatening to hurt each other? (In or outside of the family)?~~

~~Have you ever witnessed a family member who was arrested or in jail?~~

~~Have you ever had a time in your life when you did not have a place to live or enough food?~~

~~Has someone ever made you see or do something sexual? Or have you seen or heard someone else being forced to do sex acts?~~

~~Have you ever watched people using drugs, like smoking drugs or using needles?~~

~~Staff Signature/Credential~~ ______________________ ~~Date~~ ______________________

~~Individual Service Plan~~

~~Purpose~~

~~Each individual who receives services must have an Individual Service Plan that is based on the identified strengths and needs of the individual, the goals that will help address his/her needs, the services to be provided, and the activities that will take place toward achieving measurable individual outcomes. The individual seeking/ receiving services must be involved in the development of his/her service plan. For individuals under the age of eighteen (18) or who are unable to effectively participate in the planning process, a parent, legal guardian or conservator must participate in planning on the individual's behalf.~~

~~The timeline for completion of the Individual Service Plan is determined by the type of service or program the individual is entering.~~

~~The Individual Service Plan must be reviewed and revised when goals or objectives are achieved, as needs of the individual change, or according to specific service requirements but at least annually.~~

~~Individual Strengths~~

~~List strengths the individual possesses and/or demonstrates that will assist and promote successful achievement of outcomes.~~

~~Goals~~

~~The individual receiving services establishes the long term goals. Staff helps the individual set short term goals which will contribute to achievement of the long term goal(s).~~

~~Identified Barriers~~

~~List barriers that may prevent the individual from achieving successful outcomes. Barriers must include but are not limited to functional impairments in basic living skills, instrumental living skills or social skills, as indicated by an assessment instrument/ approach approved by DMH.~~

~~Individualized Areas of Need~~

~~Refer to the Initial Assessment to identify symptoms, observable behaviors, clinical areas of need and elaborate on duration (how long the symptoms/behaviors have been present or observed), frequency (how often the symptoms/behaviors are present or observed), and how the symptoms/observable behaviors create a functional impairment for the individual. Symptoms, behaviors and clinical areas of need should serve as the focus of treatment, services and supports for individuals.~~

~~Interventions, Criteria/Outcomes, Initiation and Target Dates~~

~~In order to effectively work toward achieving the long term and short term goal(s) identified by the individual receiving services, the objectives and interventions must be measurable. Each objective and intervention must have specific criteria or outcomes which clearly indicate an objective has been reached or an intervention has been completed. Each intervention must be~~

~~numbered, assigned to a service area (eg. Peer Support Services, Therapy Services, Community Support Services, etc) and have a specified target date for achievement or completion. Services identified and certified as necessary must be provided to the individual.~~ **~~All services that the individual is receiving must be indicated in relation to an objective/ intervention.~~**

~~Diagnosis~~

~~Give the written diagnosis and appropriate codes for the individual receiving services.~~

~~Community Supports~~

~~Community Support Services must be made available to the following populations: adults with serious mental illness and children/youth with serious emotional disturbance. If the individual refuses Community Support Services, the refusal must be documented in writing. Community Support Services must be offered to these specified individuals during the intake process and at a minimum of every twelve (12) months while they remain in services.~~

~~Signatory Authority~~

~~Each individual who participates in the development of the Individual Service Plan must sign the plan as evidence of his/her participation in plan development. If the Individual Service Plan is developed for adults with a serious mental illness (SMI), individuals with intellectual/ developmental disabilities, children and youth with serious emotional disturbance (SED), or individuals with a substance use disorder, a licensed Physician, a licensed Psychologist, a Psychiatric/Mental Health Nurse Practitioner, a Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Counselor, Physician Assistant or Alzheimer's Day Program Supervisor (for Alzheimer's Day programs only) must sign the Individual Service Plan, certifying the planned services are medically/therapeutically necessary.~~

~~Individual Service Plan~~	~~Name:~~ ______ ~~ID Number:~~ ______ ~~Admission Date:~~ ______ ~~Date of Plan Implementation~~ ______

☐ ~~New~~ ☐ ~~Re-Write~~ ☐ ~~Addendum~~

~~INDIVIDUAL'S STRENGTHS~~

~~LONG TERM GOALS~~ *~~(include hopes/dreams/goals)~~*	**~~SHORT TERM GOALS~~**

~~IDENTIFIED BARRIERS~~ ~~(Based on Functional Assessment)~~

~~INDIVIDUAL'S AREAS OF NEED~~				
~~INDIVIDUALIZED PLAN FOR SERVICES~~				
~~Objective #1:~~				
~~Interventions~~	~~Service Area Assigned~~	~~Criteria / Outcomes for Completion~~	~~Initiation Date:~~	~~Target Date:~~
~~1.~~				
~~2.~~				
~~3.~~				
~~Objective #2:~~				
~~Interventions~~	~~Service Area Assigned~~	~~Criteria / Outcomes for Completion~~	~~Initiation Date:~~	~~Target Date:~~
~~1.~~				
~~2.~~				
~~3.~~				
~~Objective #3:~~				
~~Interventions~~	~~Service Area Assigned~~	~~Criteria / Outcomes for Completion~~	~~Initiation Date:~~	~~Target Date:~~
~~1.~~				
~~2.~~				
~~3.~~				

~~DIAGNOSIS~~	
~~**Primary Diagnosis(es)**~~	
~~**Secondary Diagnosis(es)**~~	

~~**Community Support has been offered to me and I choose:**~~

~~☐ **YES**, I do want to participate (see Recovery Support Plan)~~

~~__________(initials of individual receiving services)~~

~~☐ **NO**, I do NOT want to participate~~

~~__________ (initials of individual receiving services)~~

~~Individual Receiving Services~~	~~Date~~	~~Parent / Legal Guardian~~	~~Date~~
~~Signature / Credentials~~	~~Date~~	~~Signature / Credentials~~	~~Date~~
~~Signature / Credentials~~	~~Date~~	~~Signature / Credentials~~	~~Date~~
~~Signature / Credentials~~	~~Date~~	~~Signature / Credentials~~	~~Date~~
~~Signature / Credentials~~	~~Date~~	~~Signature / Credentials~~	~~Date~~
~~Signature / Credentials~~	~~Date~~	~~Signature / Credentials~~	~~Date~~

~~Physician / Clinical Psychologist / Nurse Practitioner, LCSW, LMFT, LPC, PA, Alzheimer's Day Program Supervisor~~ ~~Date~~

~~Individual Crisis Support Plan~~

~~Purpose~~

~~Providers must develop an Individualized Crisis Support Plan for individuals receiving services in the following priority groups:~~

- ~~Individuals discharged from an inpatient psychiatric facility;~~
- ~~Individuals discharged from an institution;~~
- ~~Individuals discharged or transferred from Crisis Stabilization Services; and,~~
- ~~Individuals referred from Crisis Response Services.~~

~~Identifying Information~~

~~Record the individual's name, record number, date the plan was developed and the local toll-free crisis phone number.~~

~~Treatment Information~~

~~Record the individual's diagnosis as indicated on the Individual Service Plan. Explain relevant history and current potential for crisis situation. List all medications the individual is currently prescribed. Explain what may be a potential trigger for the individual to regress into a crisis situation.~~

~~Action Steps~~

~~List the action steps the individual, crisis response team and family (if indicated) will take in the event the individual is experiencing a crisis at home or in the community. Include who is responsible for initiating the response with their phone number.~~

~~Requirements~~

~~The Crisis Support Plan must be developed within 30 days of admission for all individuals receiving services in the above priority groups except those individuals admitted through crisis services. Crisis Support Plans must be developed for individuals admitted through crisis services within 72 hours of admission.~~

~~The Crisis Support Plan must be developed by the team of individuals who will have responsibilities for implementing the Plan in the event of a crisis. The Plan development team members must have at least a Bachelor's degree in mental health or a related field and must sign the Crisis Support Plan where indicated.~~

~~The Crisis Support Plan identifies what could go wrong and how people should respond. Crisis planning includes opportunities for family and team members to practice crisis response by simulating a crisis in a safe, controlled environment. The Crisis Support Plan must include who will notify who and when. The Crisis Support Plan must be portable in the sense that all team members must have a copy to refer to when needed. The Individual receiving services should also maintain a copy of the plan for reference.~~

~~Individual Crisis Support Plan~~

~~**Name**~~	
~~**ID Number**~~	
~~**Date Plan Developed**~~	
~~**Toll-free Crisis Phone Number**~~	

~~**Diagnosis:**~~	~~**Current Medications:**~~
~~**Relevant History and Potential Crisis:**~~	~~**Known Triggers:**~~

~~**Action Steps for Home**~~	~~**Person(s) Responsible and Phone Number(s)**~~	~~**Action Steps for Community Locations (specify)**~~	~~**Person(s) Responsible and Phone Number(s)**~~

~~Signature of Individual Receiving Services Date~~	~~Signature/Position Date~~
~~Signature/Position Date~~	~~Signature/Position Date~~

~~Recovery Support Plan~~

~~Purpose~~

~~The Recovery Support Plan should be completed with the Individual Receiving Services and is used as a tool to assist the individual in making plans to engage in activities and access resources designed to help support him/her in achieving and maintaining recovery/resiliency. The Recovery Support Plan replaces the previous Community Support Plan and the Substance Abuse Recovery Support Plan. This plan is meant to be a flexible document that expounds upon the information provided in the Individual Service Plan (ISP). This documentation is required for individuals receiving Community Support Services, Recovery Supports Services and Peer Support Services but can be used in conjunction with any individual's ISP.~~

~~The Recovery Support Plan must be developed within 30 days of admission for all individuals receiving services.~~

~~The Recovery Support Plan must be developed by the team of individuals who will have responsibilities for implementing the Plan during service delivery. The Plan development team members must have at least a Bachelor's degree in mental health or a related field and must sign the Recovery Support Plan where indicated.~~

~~Needs Statement from Initial Assessment and ISP~~

~~Record the individual's Needs Statement from their Initial Assessment and Individual Service Plan.~~

~~Long Term Goal(s) from the ISP~~

~~Record the individual's Long Term Goal(s) from the Individual Service Plan.~~

~~Objectives:~~

~~All Recovery Support Plans must have individualized objectives and they must be measurable. Record what the individual hopes to accomplish or achieve while receiving Support Services.~~

~~Strategies:~~

~~Describe the strategies or activities that the individual will complete to achieve the desired outcome.~~

~~Who is responsible?~~

~~Who is responsible for assisting with the completion of these objectives? This can be the individual themselves, a natural support, or a staff member. Record the person or persons responsible.~~

~~Target completion date~~

~~Explain how often activities will be conducted and the expected completion date.~~

~~Signatures~~

~~The date, signature, and credentials (if applicable) of all persons responsible for completing objectives should be recorded.~~

~~Recovery Support Plan~~

~~**Name:**~~ ____________________

~~**ID Number:**~~ ____________________

~~**Needs Statement(s) from Initial Assessment and ISP:**~~

~~**Long Term Goal(s) from ISP:**~~

~~**Objectives:**~~

~~**Strategies:**~~

~~**Who is responsible:**~~

~~**Target Completion Date:**~~

~~Individual Receiving Services~~	~~Date~~	~~Parent / Legal Guardian~~	~~Date~~
~~Direct Service Provider~~	~~Date~~	~~Direct Service Provider~~	~~Date~~

~~Progress Note~~

~~Purpose~~

~~All programs must document single therapeutic support interventions and activities that take place with/for an individual. The Progress Note can also be used “as needed” to provide supplemental documentation that cannot be adequately captured in the Weekly Progress Note.~~

~~Location~~

~~Document the location where services were provided.~~

~~Time~~

~~Document the time services began and ended along with the total amount of time services were provided.~~

~~General~~

~~Providers must document therapeutic interventions and activities (such as outpatient therapy, community support services, supported and supervised living services) utilizing the SAP format.~~

~~Summary should address the summary of activities related to the service being provided for each contact/ service event.~~

~~Assessment should address the progress made, or lack of progress made, toward the goals and objectives on the plan directing the treatment, services and/or supports for the individual (ex. ISP).~~

~~Plan should address the plan for future activities related to the service. This can include staff or individual activities.~~

~~Signatures~~

~~Staff completing the Progress Note must sign and date the form at the end of each note. The signature of a supervisor is not required but can be used to document supervision of provisionally credentialed staff.~~

~~Progress Note~~

~~Name~~ ______________________

~~ID Number~~ ______________________

~~Service Type~~ ______________________

~~Day / Date~~	~~Location~~	~~Time Began (am/pm)~~	~~Time Ended (am/pm)~~	~~Total Time~~

~~S:~~

~~A:~~

~~P:~~

~~Provider Signature/Credentials~~

~~Supervisor Signature (if applicable)~~

~~Day / Date~~	~~Location~~	~~Time Began (am/pm)~~	~~Time Ended (am/pm)~~	~~Total Time~~

~~S:~~

~~A:~~

~~P:~~

~~Provider Signature/Credentials~~

~~Supervisor Signature (if applicable)~~

~~Weekly Progress Note~~

~~Purpose~~
~~Providers must maintain documentation to verify each individual's weekly and monthly progress toward the areas of need identified on his/her Individual Service Plan.~~

~~Time~~
~~Document the time services began and ended along with the total amount of time services were provided. Indicate if an individual is absent or if it is a weekend.~~

~~Weekly Documentation~~
~~The provider must document in SAP format the activities an individual participates in or completes during the week. All activities must be listed including, community integration, job exploration, therapeutic activities, etc. Activities should be related and documented to an individual's goals/objectives/outcomes stated on the Individual Service Plan.~~

~~Staff completing the Weekly Progress Note must sign and date the form at the end of each week.~~

~~Monthly Summary~~
~~At the end of the month, a summary of progress or lack of progress toward goals/objectives/outcomes must be documented utilizing the SAP format.~~

~~Staff completing the Weekly Progress Note must sign and date the form at the end of the month. For Day Treatment Services and Psychosocial Rehabilitation Services, the Supervisor may use this form as part of the documentation of the required monthly supervision.~~

Weekly Progress Note

Name

ID Number

Service

Attendance during month of **in the year of**

Days	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Time In																															
Time Out																															
Total Time																															

Weekly Dates	Summary of Objective/Activity
1st Week	**Objective(s):**
	S: A: P:
Date:	**Signature/Credential:**
2nd Week	**Objective(s):**
	S: A: P:
Date:	**Signature/Credential:**

~~3rd Week~~	**~~Objective(s):~~**
	~~S:~~ ~~A:~~ ~~P:~~
~~Date:~~	**~~Signature/Credential:~~**
~~4th Week~~	**~~Objective(s):~~**
	~~S:~~ ~~A:~~ ~~P:~~
~~Date:~~	**~~Signature/Credential:~~**
~~5th Week~~	**~~Objective(s):~~**
	~~S:~~ ~~A:~~ ~~P:~~
~~Date:~~	**~~Signature/Credential:~~**
~~Monthly Summary~~	~~S:~~ ~~A:~~ ~~P:~~
~~Date:~~	**~~Staff Signature/Credential:~~**
~~Date:~~	**~~Supervisor Signature/Credential:~~**

~~Periodic Staffing/Review of the Individual Service Plan~~

~~Purpose~~

~~The Periodic Staffing/ Review of the Individual Service Plan (ISP) is used to document periodic review and revision in order to remain continuously current with regard to the goals and outcomes the individual receiving services is seeking to achieve. As with the original ISP, all reviews, revisions, or rewrites of the ISP must be a collaborative effort with the individual and/or legal representative and the appropriate staff.~~

~~Timelines~~

~~Review and revision must occur whenever the individual receiving services experiences a change in his/her life that impacts the goals of their current ISP. Life changes can be expected to be initially reported in progress notes and may be in one or more of the areas listed below. At a minimum, the ISP must be reviewed and revised/rewritten annually for adults and every six months for children and youth.~~

~~Changes~~

~~Any or all changes in the following areas since the last ISP review must be documented in specific detail:~~

- ~~Change in diagnosis~~
- ~~Change in symptoms~~
- ~~Change(s) in service activities~~
- ~~Change(s) in treatment/treatment recommendations~~
- ~~Other significant life change~~

~~Plan Modification~~

~~After documenting any and all changes that have occurred since the last ISP review, careful consideration should be given to the impact these changes have made on the ISP in terms of the needs expressed, goals and outcomes being pursued by the individual. The ISP should be modified or rewritten if needed to ensure ongoing progress toward achievement of the individual's ISP goals. If the ISP needs to be rewritten, there must be involvement of the treatment team and the Physician, Psychologist, Nurse Practitioner, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Counselor, Physicians Assistance or Alzheimer's Day Program Supervisor (Alzheimer's Day programs only) to determine medical necessity.~~

~~Signatory Authority~~

~~Each individual who participates in the staffing/review of the Individual Service Plan must sign the Periodic Staffing/Review of the ISP form as evidence of his/her participation in the staffing/review process.~~

# ~~Periodic Staffing/ Review of the Individual Service Plan~~	**~~Name~~** ______________ **~~ID Number~~** ______________ **~~Current Date~~** ______________ **~~Date of Last ISP/Review~~** ______________ **~~Time In~~** ______ **~~Time Out~~** ______ **~~Total~~** ______

~~Change in diagnosis since last review~~

~~Change in symptoms since last review~~

~~Change(s) in service activities since last review~~

~~Change(s) in household since last review~~

~~Change(s) in treatment/ service recommendations since last review~~

~~Other significant life change(s) since last review~~

~~Comments/Recommendations~~

~~Plan Modification ☐ No ☐ Yes ☐ Rewrite Plan~~
~~If yes, make additions/ modifications to the existing plan~~

~~Individual Receiving Services~~ ~~Date~~

~~Staff Signatures/Credentials~~ ~~Date~~

~~Staff Signatures/Credentials~~ ~~Date~~

~~Signature of Parent/Legal Guardian (if applicable)~~ ~~Date~~

~~Readmission Assessment Update~~

~~Purpose~~

~~When an individual has been discharged from a provider agency and seeks to resume services within one year of the discharge date, a Readmission Assessment Update may be utilized instead of the Initial Assessment as part of the readmission process to update information that has changed regarding the individual's needs and status.~~

~~Instructions~~

~~Update identifying information and description of need. Document any changes relating to the individual's history occurring during the lapse of service.~~

~~Description of Need~~

~~Record the reason(s) the individual is seeking services.~~

~~Status Updates~~

~~Any changes relating to individual's status areas (medical, mental health, substance abuse/use, social/cultural, educational/vocational) that have occurred during the gap in service must be documented in detailed narrative format. Responses of "Yes", "No", "Present", "Not Present" are not acceptable.~~

~~Indication of Functional Limitation(s)~~

~~An assessment must be conducted and the results documented for the major life areas specified for each individual seeking readmission to services.~~

~~The Child and Adolescent Functional Assessment Scale (CAFAS) is required for all children/youth receiving mental health services. The CAFAS must be completed within 30 days for all children/youth receiving mental health services.~~

~~An approved functional assessment is required for all adults receiving mental health services. An approved functional assessment must be completed within 30 days for all adults receiving mental health services. DMH will review and approve a functional assessment for use with the adult SMI population.~~

~~An approved functional assessment is required for all individuals receiving substance use disorder services. DMH will review and approve a functional assessment for use with the SUD population.~~

~~Staff Requirement~~

~~The Readmission Assessment Update must be completed by an individual with at least a Master's degree in mental health or intellectual/developmental disabilities, or a related field and who has either (1) a professional license or (2) a DMH credential as a Mental Health Therapist or Intellectual/Developmental Disabilities Therapist (as appropriate to the population being served) or Alzheimer's Day Program Supervisor (Alzheimer's Day Programs only).~~

~~**Readmission Assessment Update**~~	~~**Name**~~ ____________________ ~~**ID Number**~~ ____________________ ~~**Readmission Date**~~ ____________________

~~**Informant**: ❑ Individual receiving services ❑ Other Relationship to individual:~~

~~**LEGAL INFORMATION**~~	
~~Name of Guardian / Custodian:~~	~~Guardianship Documentation Verified:~~ ~~☐ Yes ☐ No~~
~~Guardian / Custodian Address:~~	~~Guardian / Custodian Phone Number:~~

~~**DESCRIPTION OF NEED**~~

~~What is your reason for seeking services today?~~

~~What specific needs are you currently having?~~

~~Why was the record closed?~~

~~Status Updates~~

~~**Medical Status (Record current medications on the Medication/Drug Use Profile):**~~

~~*Allergies*~~

~~*Physical impairments*~~

~~*Surgeries*~~

~~*Special diets*~~

~~*Appetite issues or problems*~~

~~*Sleep issues or problems*~~

~~*Current or chronic diseases (high blood pressure, cancer, other)*~~

~~*Other pertinent medical information*~~

~~*(For women only) Are you pregnant?*~~

~~Mental Health Status:~~

~~Recent psychiatric issues~~

~~Homicidal behavior~~

~~Suicidal behavior~~

~~Other counseling and/or therapeutic experiences~~

~~Traumatic Event Or Exposure Status (Note Or Describe As Appropriate):~~

~~Serious accidents~~

~~Natural disaster~~

~~Witness to a traumatic event~~

~~Sexual assault~~

~~Physical assault (with or without weapon)~~

~~Close friend or family member murdered~~

~~Homeless~~

~~Victim of stalking or bullying~~

~~Other (specify)~~

~~Substance Use Status:~~

~~Use or abuse by the individual~~

~~Age of onset~~ ________

~~Patterns of use/abuse:~~ *~~How much?~~* ________

~~How often?~~ ________

~~Methods of use:~~ *~~smoke~~* ❑ *~~snort~~* ❑ *~~inject~~* ❑ *~~insert~~* ❑ *~~inhale~~* ❑

~~Resulting circumstances?~~

~~**Social/Cultural Status:**~~

~~*Immediate household/family configuration*~~

~~*Marital status*~~

~~*Relationship with family members*~~

~~*Type of family support available*~~

~~*Type of social support available*~~

~~*Types and amounts of social involvement/leisure activities*~~

~~*Any religious/cultural/ethnic aspects that should be considered*~~

~~**Educational/Vocational Status:**~~

~~*Highest grade completed*~~ ____________________

~~*If currently in school (child or youth), regular classroom placement?*~~ ❑ ~~*Yes*~~ ❑ ~~*No*~~

~~*List all additional educational services child is receiving*~~

~~*Any repeated grades?*~~ ❑ ~~*No*~~ ❑ ~~*Yes*~~ ~~*Explain:*~~

~~*Suspensions/expulsions?*~~ ❑ ~~*No*~~ ❑ ~~*Yes*~~ ~~*Describe:*~~

~~*Other education issues*~~ ____________________

~~*Vocational training, if any*~~ ____________________

~~*Current employment*~~ ____________________

~~*Previous employment*~~

~~**Comments:**~~

~~Indication Of Functional Limitation(s):~~
~~**(Check Major Life Areas Affected)**~~

	~~Basic living skills (eating, bathing, dressing, etc.)~~
	~~Instrumental living skills (maintain a household, managing money, getting around the community, taking prescribed medications, etc.)~~
	~~Social functioning (ability to function within the family, vocational or educational function, other social contexts, etc.)~~

~~**Signature/Credentials**~~ ~~**Date**~~

~~Substance Use Disorder Specific Assessment~~

~~Purpose~~

~~This information must be documented if substance use disorder services are provided or if substance use disorder is suspected. This form must be completed in addition to the Initial Assessment and is applicable to youth and adults. This form should specifically address how substance use history has created impairment.~~

~~Treatment Modality Abbreviations~~

~~OP~~	~~Outpatient Services~~
~~IOP~~	~~Intensive Outpatient Services~~
~~PR~~	~~Primary Residential~~
~~TR~~	~~Transitional Residential~~
~~PHP~~	~~Partial Hospitalization~~

~~Detailed Substance Use History~~

~~This section of the assessment allows the evaluator to document details of the individual's history of substance use. The evaluator should document the substance use; include the age of onset, and the pattern of use.~~

~~Prior Substance Use Disorder Treatment~~

~~This section of the assessment allows the evaluator to document the individual's prior history of substance use disorder treatment. Location, date, completion of prior treatment, outcome and length of treatment should all be documented in this section.~~

~~Evaluator's Assessment of Attitude~~

~~This part of the assessment allows the evaluator to document the individual's level of denial and/or willingness to change with regard to their use of alcohol and other drugs.~~

~~Family History of Alcohol and/other Drugs~~

~~This section of the assessment allows the evaluator to document the individual's family history of substance use.~~

~~**Substance Use Disorder Specific Assessment**~~	~~**Name**~~ ____________________ ~~**ID Number**~~ ____________________ ~~**Date**~~ ____________________ ~~**Time In:**~~ ~~**Time Out:**~~ ~~**Total:**~~
~~**Admission Date:**~~	~~**Treatment Service: OP___IOP___PR___TR____PHP___**~~

~~DUI Specific History~~

~~DUI Offender?~~ ❑ ~~First time~~ ❑ ~~2+Offenses~~ ❑ ~~Not applicable~~

~~Is the individual's driver's license currently suspended?~~ ❑ ~~Yes~~ ❑ ~~No~~

~~If yes, was the individual enrolled in or referred to a *certified* DUI Treatment Program?~~ ❑ ~~Yes~~ ❑ ~~No~~

~~Substance Use History~~ ~~(Explain use, drug of choice, include age of onset, and pattern of use)~~

~~How much money would you say you've spent on substances during the past 30 days?~~____________________

~~What was your longest period of abstinence?~~____________ ~~How was abstinence maintained?~~ ____________________

~~On a scale of 1-5, how important is treatment to you now? (5 being most important)~~ ____________

~~Prior Substance Use Disorder Treatment~~ ~~(Location, date, completion status, outcome, length of recovery after treatment)~~

~~Evaluator's Assessment of Individuals Attitude Regarding Use of Alcohol and/or Other Drugs~~

~~Level of Denial: (circle one)~~ ~~None Low Moderate High Unsure~~

~~Willingness to Change: (circle one)~~ ~~None Low Moderate High Unsure~~

~~Family History of Alcohol and/or Other Drugs~~

~~SIGNATURES / CREDENTIALS~~

~~Staff Signatures/Credentials~~ ~~Date~~

~~Section D~~
~~As Needed~~

~~Initial Assessment and Crisis Contact Summary~~

~~Serious Incident Report~~

~~Medical Examination~~

~~Documentation of Healthcare Provider Visits~~

~~Self-Administration Medication Observation Log~~

~~Telephone/ Visitation Agreement~~

~~Search and Seizure Report~~

~~Physical Escort Log~~

~~Time Out Log~~

~~Seclusion Behavior Management Log~~

~~Service Termination/ Change Summary~~

~~Provider Discharge Summary~~

~~Initial Assessment and Crisis Contact Summary for Crisis Response Contacts~~

~~Purpose~~

~~The Initial Assessment and Contact Log for Crisis Response Contacts is used to document the provision of emergency/crisis contacts with individuals seeking services from a provider who are not already receiving other mental health services from the provider.~~

~~Identifying Information~~

~~Record the name of the individual receiving crisis services. Issue and record a client identification number. The Date of Contact will also be the Date of Admission. Enter the individual's Social Security and Medicaid numbers. Record the time the contact began and ended. Indicate the type of crisis service delivered (Mobile Crisis Services, Telephone Crisis Response, or Walk-in Crisis Response). If the contact was made Face to Face, include the location where the contact took place and if the contact was made by phone, include the phone number of the caller. List by relationship any other individuals involved with the emergency/crisis or any referral source (i.e. sister).~~

~~Presenting Need~~

~~Document the reason(s) the individual is seeking emergency/crisis services.~~

~~Actions Taken by Staff~~

~~Document the steps taken to assess and resolve the emergency/crisis. Record if anyone was contacted on behalf of the individual in crisis. If no one else was notified, indicate why it was not necessary.~~

~~Initial Behavioral Observations~~

~~Document the staff's impressions of the individual's behaviors. Include additional comments at the end of the section.~~

~~Resolution~~

~~Document the condition of the individual at the end of the contact; indicate where the individual and/or family were referred and if a subsequent appointment was made for the individual with the provider, note the date and time of the appointment.~~

~~Required Data~~

~~This information is required by the Department of Mental Health and is to be submitted to the Central Data Repository. If you are unable to obtain this information, please mark as "unknown." The staff person responding to the individual in crisis and documenting the contact must sign this form and include their professional credentials.~~

~~Initial Assessment and Crisis Contact Summary for Crisis Response Contacts~~

~~Name:~~ ______________________________

~~ID Number:~~ ______________________________

~~Contact/ Admit Date:~~ ______________________________

~~Medicaid #:~~ ______________ **~~SS#~~** ______________

~~Time In:~~ ~~Time Out:~~ ~~Total Time:~~

~~Type of Contact:~~

- ☐ ~~Mobile Crisis Service~~ ~~Location:~~ ______________________________
- ☐ ~~Telephone Crisis Response~~ ~~Number:~~ ______________________________
- ☐ ~~Walk-in Crisis Response~~

~~Others Involved:~~

~~Presenting Needs (the factors indicating a need for Crisis ResponseServices)~~

~~Actions Taken by Staff:~~

~~Initial Behavioral Observations~~

~~Speech: · Appropriate ·Slowed ·Mechanical ·Rapid ·Other~~

~~Behavior: · Appropriate · Withdrawn ·Bizarre ·Volatile · Other~~

~~Appearance: · Appropriate · Disheveled Unclean ·Inappropriately dressed~~
~~· Other Phone Contact~~

~~Mood: · Appropriate Manic Depressed Labile Irritable · Other~~

~~Affect: · Appropriate Flat Labile · Other~~

~~Oriented to: · Place Time Person · Situation · Other~~

~~Thought Content: Appropriate · Incoherent · Obsessive · Delusional · Paranoid · Other~~

~~Memory: · Appropriate · Repressed · Confused · Other~~

~~Intelligence: · Average · Above Average · Below Average~~

~~Judgment/Insight: ·Appropriate ·Impaired ·Suicidal Homicidal ·Other~~

~~Hallucinations: · Auditory · Visual · Tactile · Other~~

~~Comments:~~

~~**Resolution**~~

~~Condition of the Individual at Conclusion of Contact~~	~~Referrals Made by Staff~~
	~~Appointment with the Provider~~ ~~Date:~~ ~~Time:~~

~~Required Data~~

~~(Please mark as Unknown if Information is Unavailable)~~

~~Birth Date:~~	~~Age:~~	~~Gender:~~
~~Race:~~	~~Education Level:~~	~~Marital Status:~~
~~County of Residence:~~	~~Living Arrangement:~~	~~Type of Residence:~~
~~Employment Status:~~	~~Legal Status:~~	~~Primary Income Source:~~
~~Annual Income:~~	~~# in Household:~~	~~SSI/SSDI Eligibility:~~
~~Veteran Status:~~	~~Physical Impairments:~~	~~Service Code:~~

~~Staff Signature/Credentials:~~

~~Serious Incident Report~~

~~**Date of Report:** The date this report was written~~

~~**Date of Incident:** The date the incident occurred~~

~~**Time of Incident:** The time the incident occurred; make sure to check am or pm~~

~~**Provider Name:** The name of the Provider (example: Region X Mental Health)~~

~~**Program Name:** The Name of the specific program within the Provider agency (example: Golden Rainbows PSR). In some instances the Provider Name may actually be the Program; for instance with a smaller private Provider.~~

~~**Service:** The name of the specific Service for which the Program is certified. (example: Psychosocial Rehabilitation Services)~~

~~**Reported by:** The name of the person completing the incident report. If the incident was reported to the person completing the form, the names of the initial reporter(s) will be included in the **Description of Incident**, **Person(s) Involved in Incident** and **Witnesses** sections.~~

~~**Event Codes:**~~

~~**SU** Suicide attempt, or Completed Suicide~~

~~**EMG** Treatment received at an Emergency Room. Do not include trips to Emergency Room that do not result in treatment~~

~~**SR** Any Seclusion or Restraints~~

~~**ACL** An unexpected absence from a community living program~~

~~**ABN** Any abuse or neglect of an individual receiving services, either suspected or confirmed~~

~~**WKV** Any workplace violence occurring on the property of a certified Provider, or at a Provider sponsored event~~

~~**ELP** Elopement of an individual receiving services~~

~~**DIS** Any Disaster that effects the normal functioning of a certified Provider. Do not include reports of Disaster Drills.~~

~~**MED** Any confirmed Medication Errors~~

~~**INJ**~~ ~~Any serious injuries sustained by an individual receiving services. Minor injuries need not be reported. Injuries resulting in fractures, stitches or sutures (or preliminary x-rays to determine extent of injury) are considered serious.~~

~~**EVC**~~ ~~Any event that requires evacuation of the premises. Do not include drills.~~

~~**OTH**~~ ~~Any incident that is deemed serious by the Provider, but is not listed above. Details should be given in the Description of Incident section.~~

~~**Description of Incident:**~~

~~Give as detailed an account as possible of the incident in the space provided.~~

~~**Person(s) Involved In Incident:**~~

~~List first and last names (if known) of all individuals involved in the incident. This should include all alleged victims and alleged perpetrators (if applicable). Use the provided check boxes to indicate whether or not the individual(s) is on the ID/DD waiver.~~

~~**Witnesses:**~~ ~~List the names of any verified or potential witnesses to the incident.~~

~~**Possible Contributing Factors:**~~

~~List any identified possible contributing factors to the incident. (example: a wet floor that resulted in a fall which caused a hip fracture)~~

~~**Consequences/Follow Up Actions:**~~

~~List any actions that the Provider has taken since the incident occurred to lessen the chances of it happening again. Any disciplinary actions that have been taken should also be included (example: Administrative Leave)~~

~~**Any and all authoritative bodies to which this incident has been reported and the dates of those reports.**~~ ~~(example: Department of Health, 12/3/12; Attorney General's Office, 12/4/12)~~

~~**Has A Report Been Made Within the Agency:**~~

~~Mark "yes" here to acknowledge that a report of the incident has been made to the proper authoritative body within the agency. For example, the agency may have a Risk Management Department to which all incidents should be reported internally. Or, if the agency does not have a formal Risk Management Department, mark "yes" if a report has been made to the Executive Director.~~

~~**If yes, to whom has the Report of Incident been made?**~~

~~Provide the names and positions of each person to whom the incident has been reported.~~

~~**At the time of this report, is the Agency conducting an Internal Investigation**?~~

~~Mark “yes” if the agency is conducting its own internal investigation.~~

~~**If yes, is the Agency’s Investigation Active or Closed?**~~

~~If the investigation is ongoing, mark “Active.” If the investigation has been completed, mark “closed.”~~

~~**Is this a high visibility Incident?**~~

~~Visibility refers to the likelihood that the incident will be reported by the media. If there is a good possibility that the incident will be reported in the media, check “yes.”~~

~~Serious Incident Reporting Form~~

~~Date of Report:~~	**~~Date of Incident:~~**	**~~Time of Incident: ☐ am ☐ pm~~**
~~Provider Name:~~		
~~Program Name:~~	**~~Service:~~**	
~~Reported By:~~		

~~Event Codes (Check All That Apply)~~

~~☐ **SU** Suicide (Attempt or Completed)~~	~~☐ **EMG** Emergency Room Treatment~~	~~☐ **SR** Seclusion/Restraint~~
~~☐ **ACL** Absence from Community Living~~	~~☐ **ABN** Abuse/Neglect~~	~~☐ **WKV** Workplace Violence~~
~~☐ **ELP** Elopement~~	~~☐ **DIS** Disaster~~	~~☐ **MED** Medication Error~~
~~☐ **INJ** Injury~~	~~☐ **EVC** Evacuation~~	~~☐ **OTH** Other (describe below in narrative)~~

~~Description of Incident:~~

~~**Individual(s) Involved In Incident (include case # with name if known)**~~	~~Is this individual on the ID/DD Waiver?~~ ~~☐ **Yes** ☐ **No**~~
	~~If yes, was Support Coordination notified?~~ ~~☐ Yes ☐ No~~

~~**Witnesses:**~~
~~**Possible Contributing Factors:**~~
~~**Consequences/Follow Up Actions:**~~
~~**Any and all authoritative bodies to which this incident has been reported and the dates of those reports.**~~
~~**Has a Report of Incident been made within the agency?**~~ ~~☐ **Yes** ☐ **No**~~
~~**If yes, to whom has the Report of Incident been made?**~~ __________ __________ ~~Name Position~~ __________ __________ ~~Name Position~~ __________ __________ ~~Name Position~~
~~**At the time of this report, is the Agency conducting an Internal Investigation?**~~ ~~☐ **Yes** ☐ **No**~~
~~**If yes, is the Agency's Investigation Active or Closed?**~~
~~**Is this a high visibility Incident?**~~ ~~☐ **Yes** ☐ **No**~~

~~**Medical Examination**~~

~~The DMH Operational Standards require that each individual served in any DMH certified supervised living and residential treatment program must have a documented Medical Examination in the individual's record. The examination must take place within 72 hours of admission or not more than 30 days prior to admission and be conducted by a licensed physician, certified nurse practitioner or certified physician's assistant. No individual may remain in the program unless a medical examination is completed and documented.~~

~~Components of the medical examination and report include but are not limited to:~~

- ~~Individual's personal information~~
- ~~Physician's information (name, contact information, other)~~
- ~~Examination information (blood pressure, pulse, height, weight, current diagnosis, current medications, statement of freedom from communicable disease, physical and dietary limitations, and allergies)~~

~~The medical examination report must be signed by a licensed physician/nurse practitioner/ certified physician's assistant.~~

~~For ID/DD Waiver, the medical exam obtained as part of the admission process can be used for up to one year from the date of the exam.~~

~~Medical Examination~~

~~Physician's Name:~~		~~Date of Evaluation~~	
~~Physician's Address:~~		~~Physician's Phone #~~	
~~Person Receiving Examination:~~		~~DOB~~	
		~~Age~~	

~~Height:~~		~~Temperature:~~		~~Blood Pressure:~~	
~~Weight~~		~~Head Circumference:~~		~~General Appearance:~~	

~~Check~~	~~Normal~~	~~Abnormal~~	~~Remarks~~
~~1. Head~~			
~~2. Fontanelle~~			
~~3. Skin~~			
~~4. Lymph Nodes~~			
~~5. Facies~~			
~~6. Eyes a. Right~~			
~~b. Left~~			
~~7. Ears a. Right~~			
~~b. Left~~			
~~8. Nose~~			
~~9. Mouth~~			
~~10. Teeth and Gums~~			
~~11. Tongue~~			
~~12. Pharynx & Palate~~			
~~13. Neck~~			
~~14. Thorax~~			
~~15. Heart~~			
~~16. Lungs~~			
~~17. Abdomen~~			
~~18. Breasts~~			
~~19. Genitals~~			
~~20. Spine~~			
~~21. Extremities~~			
~~22. Neurological:~~			
~~a. Cranial~~			
~~b. Reflexes~~			
~~c. Neuromuscular~~			
~~d. Stand and Gait~~			
~~e. Mood/ Behavior~~			
~~23. Urine~~			
~~24. CBC~~			

~~Current Medications:~~	~~Special Dietary Requirements:~~

~~Based upon the results of this examination and the additional information provided, this person is sufficiently free from disease and does not have any health conditions that would create a hazard for other people.~~

______________________________ ______________

~~Signature of Healthcare Provider~~ ~~Date~~

~~Documentation of Healthcare Provider Visits~~

~~Purpose~~
~~This form ensures that Supervised Living Services, Shared Supported Living Services, Supported Living Services and Therapeutic Group Home Services providers are assisting individuals in accessing routine healthcare services. This form is required for Supervised Living Services and Therapeutic Group Home Services but can be used by any service provider to document access to routine healthcare.~~

~~Timelines~~
~~This form must be completed each time the individual interacts with a healthcare provider of any type.~~

~~Name/Type of Healthcare Provider~~
~~List the name and type of the healthcare provider. List the credential(s) of the provider. Types of healthcare providers are physicians, nurses, pharmacists, optometrists, etc.~~

~~Reason for Visit~~
~~Provide a detailed description of why the individual is meeting with the healthcare provider.~~

~~Outcomes/Results~~
~~Provide a detailed description of the outcome of the meeting with the healthcare provider. This includes any diagnosis(es), procedures conducted during the visit, and any procedures/follow-up required. If a procedure of any type is scheduled, provide the date.~~

~~Medications~~
~~Medications ordered or changed must be documented on the Medication/ Emergency Contact Information Form.~~

~~Change(s) in Existing Prescriptions~~
~~If the healthcare provider changes a currently prescribed medication(s), provide the same information as required above and include the reason for the change(s). Update the Medication/Emergency Contact Information form as needed.~~

Documentation of Healthcare Provider Visits

Name ______________________

ID Number ______________________

Date ______________________

Name of Health Care Provider: ______________________

Type of Health Care Provider: ______________________

Reason for Visit:

Outcomes/Results

Diagnosis(es) (if applicable): ______________________

Procedure(s) conducted: ______________________

Procedure(s) ordered: ______________________ Date: __________

Describe any needed follow up, including dates: ______________________

Source of Information

- ❑ Provider/ Staff participated in the visit
- ❑ Family/ Guardian participated in the visit and provided results of the visit to the program
- ❑ Provider assisted with access to healthcare but did not participate in the visit
- ❑ Release of records completed
- ❑ Records requested from healthcare provider

______________________ ______________________

Staff Signature/Credential Date

~~Self-Administered Medication Observation Log~~

~~Purpose~~

~~This form should be used to document all medications that are self-administered in day programs and in all Supervised Living settings. This form is not intended for use by nurses administering medication.~~

~~Forms can be prepared or generated by the pharmacy for up to one month for regularly prescribed medication. Agencies must have policies and procedures to account for changes to medications mid cycle. Signatures must be original at the time of observation.~~

~~Identifying Information~~

~~Enter the name and ID number of the individual.~~

~~Documentation~~

~~The provider must enter all required information.~~

~~Signature~~

~~The signature of the staff completing the log must be included. Two or more medications, administered at the same time, can be signed with a single signature on a diagonal line across rows. Signatures must be original and cannot be typed.~~

~~Self-Administered Medication Observation Log~~

~~Name~~ ____________________

~~ID Number~~ ____________________

~~Program~~ ____________________

~~Time/ Date~~	~~Medication~~	~~Dosage~~	~~Individual Signature~~	~~Staff Observation Signature/ Credential~~

~~Telephone/Visitation Agreement~~

~~Purpose~~

~~Individuals receiving services have the right to privacy as it pertains to the acknowledgement of their presence in the program with regard to visitors as much as physically possible. Individuals receiving services also have the right to determine from whom they will accept phone calls and/or visitation. The fully executed Telephone/Visitation Agreement serves to allow acknowledgement of the individual's presence in the program to those listed in and according to the terms detailed in the Agreement. This form is required for Substance Use Residential Treatment programs, Supervised Living programs, Shared Supported Living programs and Crisis Stabilization programs.~~

~~Timeline~~

~~The Telephone/Visitation Agreement must be completed upon admission/re-admission when required. The Agreement must be reviewed or updated upon the request of the individual receiving services.~~

~~Telephone Calls~~

~~Check only the box that applies. If the individual agrees to accept all telephone calls regardless of source, the first box should be checked. If the individual agrees to only accept calls from specific individuals, the second box should be checked and the name(s), phone number, and relationship of those individuals must be documented.~~

~~Visits~~

~~Check only the box that applies. If the individual agrees to accept all visitors, the first box should be checked. If the individual agrees to only accept visits from specific individuals, the second box should be checked and the name(s), phone number, and relationship of those individuals must be documented.~~

~~Staff and Facility-specific Visitors~~

~~By signing the Telephone/Visitation Agreement, the individual receiving services also acknowledges their understanding that the program cannot be held responsible for disclosures made by other individuals who may enter the premises.~~

~~Telephone/Visitation Agreement~~

~~Name~~ ______

~~ID Number~~ ______

~~While receiving services from:~~ ______
~~(Provider)~~

~~I give consent to receive phone calls and visits from those specific persons named in the sections below and who are outside the program/facility for support and coordination of my treatment services.~~

☐ ~~I agree to have my participation in this program acknowledged and accept telephone calls from any individuals.~~

☐ ~~I agree to have my participation in this program acknowledged and accept telephone calls only from the following named individuals:~~

~~**Name**~~	~~**Telephone Number(s)**~~	~~**Relationship**~~

☐ ~~I agree to accept any individual as a visitor.~~

☐ ~~I agree to accept as visitors the following named individuals only:~~

~~**Name**~~	~~**Telephone Number(s)**~~	~~**Relationship**~~

~~I understand this consent will expire upon my discharge from the program. I may revoke this consent at any time except to the extent that action has already taken place.~~

~~I understand that interns and delivery/maintenance people enter the premises on occasion and I will not hold the service provider staff responsible for any visitors that may disclose my presence in this program.~~

______ ______

~~Individual Receiving Services~~ ~~Date~~ ~~Authorized Representative~~ ~~Date~~

______ ______

~~Signature/Credential~~ ~~Date~~ ~~Relationship to Individual~~

~~Search and Seizure Report~~

~~Purpose~~

~~The form serves as documentation that a search of an individual and/or his/her possessions and/or space was conducted by a DMH certified provider. A separate form must be completed for each individual receiving services who is included in the search.~~

~~Reason for the Search~~

~~Explain the specific reason the search was conducted.~~

~~Description of Search~~

~~Describe, in detail, all aspects of the search. Indicate the type of search conducted. Document the specific location (room, building, program area, other), specific items searched, method of search, and duration of search.~~

~~Items Seized~~

~~List all of the items seized as a result of the search. Specify source or location of items seized if items were seized from more than one location or source.~~

~~Staff Involvement~~

~~The staff person who authorized the search is to sign the form and list his/her credentials and position title. The same is true for any other staff involved in or witnessing the search.~~

~~Search and Seizure Report~~

~~Name~~ ______________________

~~ID Number~~ ______________________

~~Date~~ ______________________

~~Time~~ **~~AM~~** **~~PM~~**

~~Reason for Search~~

~~Description of Search~~

~~Type of Search~~

☐ ~~Person~~ ☐ ~~Room~~ ☐ ~~Locker~~ ☐ ~~Possessions~~ ☐ ~~Other~~ ______________________

~~Location~~ __________

~~List of Items Seized and Source(s) of Items~~

~~Staff Involvement~~

~~Authorized By~~ ______________________

~~Signature/credentials/position title~~

~~Conducted By~~ ______________________

~~Signature/credentials/position title~~

~~Other person(s) involved in or witnessing the search (signature/credential/position title):~~

~~Physical Escort Log~~

~~Purpose~~

~~When an individual is physically escorted away from a service or living area due to inappropriate behavior, the intervention must be documented. A physical escort is the temporary holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing an individual who is acting out to walk to a safe location.~~

~~Identifying Information~~

~~Enter the name and record number of the individual being escorted.~~

~~Presenting Need~~

~~The time, date and detailed description of the events necessitating an escort must be documented. Describe in detail the individual's behavior and the type of escort used. All staff physically involved in the escort must be documented. Describe all other attempts to deescalate the individual's behavior. If less restrictive methods of de-escalation are bypassed, explain staff reasoning. The supervisory staff person must document the face-to-face assessments provided during the escort, including the time the assessments began and ended. List all dates the individual was escorted within the last thirty (30) days. Indicate any treatment recommendations and date Individual Service Plan was modified (if necessary.) The primary staff implementing the escort must sign the documentation. Staff who witnessed but did not participate in the escort must also sign the finalized log.~~

~~Requirements~~

~~Physical Escort cannot be utilized more than three (3) times in a thirty (30) day period unless a Behavior Support Plan has been developed and approved by the program's Clinical Director and ordered by a physician or other licensed practitioner. Physical Escort cannot be used as part of a standing order or on an as needed basis. If an individual is physically escorted, the treating physician must be consulted within twenty-four (24) hours.~~

~~Timeline~~

~~Documentation of the physical assessments must take place when they occur. The form must be completed in its entirety by the end of the working day in which the intervention took place.~~

~~Physical Escort Log~~

~~Name~~ ______

~~ID Number~~ ______

~~Date~~ ______

~~Time intervention began:~~ ~~AM/PM~~ ~~ended:~~ ~~AM/PM~~

~~Describe the precipitating events necessitating escort:~~

~~Describe the behavior warranting escort:~~

~~Describe type of escort used:~~

~~List all staff members (regardless of position) that were involved in escort:~~

~~Describe ineffective/less restrictive alternatives attempted prior to escort:~~

~~Describe individual’s behavior during escort:~~

~~Supervisory staff person's face-to-face assessment of the individual's mental and physical well being during escort:~~

~~Time 1st assessment began:~~ ______ ~~AM/PM~~ ~~Ended:~~ ______ ~~AM/PM~~

~~Time 2nd assessment began:~~ ______ ~~AM/PM~~ ~~Ended:~~ ______ ~~AM/PM~~

~~Time 3rd assessment began:~~ ______ ~~AM/PM~~ ~~Ended:~~ ______ ~~AM/PM~~

~~Signature/credentials of supervisor staff:~~ ______

~~Date(s) individual restrained in the last 30 days:~~ ______ ______ ______ ______

~~Is a Behavior Support Plan warranted?~~ ❑ ~~Yes~~ ❑ ~~No~~

~~Name of treating physician consulted:~~ ______ ~~Date:~~ ______ ~~Time:~~ ______

~~Treatment Recommendations:~~

~~Date Individual Service Plan Modified:~~

~~Signature of Staff Implementing Escort~~ ______

~~Signature(s) of Other Staff Witness(es)~~ ______

______

______

~~Time Out Log~~

~~Purpose~~

~~When an individual is placed in time out due to inappropriate behavior, the intervention must be documented.~~

~~Identifying Information~~

~~Enter the name and record number of the individual being placed in time out.~~

~~Presenting Need~~

~~The time, date and detailed description of the events necessitating the time out must be documented. Describe in detail the individual's behavior. All staff physically involved in the time out must be documented. Describe all other attempts to de-escalate the individual's behavior. If less restrictive methods of de-escalation are bypassed, explain staff reasoning. Document the visual assessments provided during the time out. Indicate any treatment recommendations and date Individual Service Plan was modified (if necessary.) The primary staff implementing the time out must sign the documentation. Staff who witnessed but did not participate in the time out must also sign the finalized log.~~

~~Requirements~~

~~The use of time out must be justified and approved in the Individual Service Plan. Prior to the use of time out, there must be a written Behavior Support Plan, which is developed in accordance with the Individual Service Plan, and must be approved by the program's clinical director. An individual cannot be placed in time out for more than one (1) hour. The individual must be visually observed by staff during time out at least once every twenty (20) minutes.~~

~~Time out cannot be used for persons who have IDD.~~

~~Timeline~~

~~Documentation of visual assessments is made at the time of each observation. The form must be completed in its entirety by the end of the working day in which the time out took place.~~

~~Time Out Log~~

~~Name~~ ______________________

~~ID Number~~ ______________________

~~Date~~ ______________________

~~Time intervention began:~~ ~~AM/PM~~ ~~ended:~~ ~~AM/PM~~

~~Describe the precipitating events necessitating time out~~

~~Describe the behavior warranting time out~~

~~Describe ineffective/less restrictive alternatives attempted prior to time out~~

~~Describe individual's behavior during time out, based on visual assessments~~

~~Does the Individual Service Plan require modification?~~ ~~Yes~~ ❑ ~~No~~ ❑

~~Signature of Staff Implementing Time Out~~

~~Signature of Staff Observing Time Out~~

~~Signature/credentials of Supervisory Staff~~

~~Seclusion Behavior Management Log~~

~~Purpose~~

~~The DMH only allows seclusion to be used in a Crisis Stabilization Unit (CSU) and only in accordance with the order of a physician or other licensed independent practitioner, as permitted by State licensure rules/regulations governing the scope of practice of the independent practitioner. Programs utilizing Seclusion as part of an approved Individual Service Plan (ISP) must document all aspects of the Seclusion intervention using the Seclusion Behavior Management Log. There must be a written Behavior Support Plan developed in accordance with the ISP and with signature approval by the Clinical Director.~~

~~Seclusion cannot be used for persons who have IDD.~~

~~Timeline~~

~~The Seclusion Behavior Management Log must be completed during the Seclusion intervention in order to accurately record all aspects of the intervention. Each written order for Seclusion must be limited to four (4) hours. After the original order expires, a physician or licensed independent practitioner as provided above must see and assess the individual in Seclusion before issuing a new order. Staff must observe the individual in seclusion every 15 minutes and record the observation.~~

~~Completion of the Log~~

~~The time the Seclusion intervention began and ended must be documented.~~

~~The precipitating event(s) and behavior(s) causing the Seclusion intervention to be implemented must be documented in detail.~~

~~The less-restrictive interventions that were implemented prior to the use of Seclusion must be documented in detail.~~

~~Visual observation by staff while the individual is in Seclusion and a description of the individual's behavior while in Seclusion must be documented in detail.~~

~~Staff Signatures~~

~~The Seclusion Behavior Management Log must be signed by both the staff person implementing the Seclusion and the staff person observing the Seclusion.~~

~~Seclusion Behavior Management Log~~

~~ID#~~	
~~Name of Individual Being Placed in Seclusion~~	

~~Time Intervention Began:~~ ~~Ended:~~	~~Date:~~

~~Precipitating Events Necessitating Seclusion:~~

~~Behavior Warranting Intervention:~~

~~List all Staff (regardless of position) that were involved in seclusion:~~

~~Ineffective Less Restrictive Alternatives Attempted Prior to Intervention:~~

~~Description of Individual's Behavior During Seclusion:~~

~~Signature of Staff Implementing Seclusion~~ ~~Signature of Other Staff Witness(es)~~

~~Physician or Other Licensed Practitioner's Evaluation of the Need for Seclusion (within one hour of onset):~~

~~Signature of Physician or other Licensed Practitioner~~

~~15 Minute Observations Indicated by Staff Signature~~	
~~1.~~	~~7.~~
~~2.~~	~~8.~~
~~3.~~	~~9.~~
~~4.~~	~~10.~~
~~5.~~	~~11.~~
~~6.~~	~~12.~~

~~Service Termination/Change Summary~~

~~Purpose~~

~~Documentation must be provided and maintained when an individual receiving services transfers between services. The Service Termination/Change Summary serves to document an individual's change(s) of service(s) with the current provider which may include transfers from one program or service area to another.~~
~~For example: if an individual receives Service A and Service B and will no longer receive Service A- a Service Termination/ Change Summary must be completed for Service A.~~

~~Service(s) initiated must be part of the Individual Service plan. If they are not on the ISP at the time of change, a revision to the ISP must be completed and certified by those with signatory authority and signed by the individual receiving services or legal representative.~~

~~Service Termination/Change Information~~

~~The staff member completing the Service Termination/Change Summary must provide as much information as necessary to clearly describe the transfer that is taking place. It must be documented if the transfer is expected to be temporary or permanent, with dates provided when appropriate or available.~~

~~Date of Transfer~~

~~The date must indicate the point at which the transfer will become effective. One Service Termination/Change Summary can be used for more than one service change that all become effective the same date. Separate forms must be used for transfers that have different effective dates.~~

~~Signatory Authority~~

~~The staff member authorizing the change must sign and date the form.~~

~~Service Termination/Change Summary~~

~~Name~~

~~ID Number~~

~~Date~~ ______________________________

- ~~☐ Service Termination~~
- ~~☐ Service Change~~

~~Effective Date of Service Change/Termination:~~ ______________

~~Service Termination or Change is expected to be~~ ~~☐ Temporary~~ ~~☐ Permanent~~

~~Reasons for Service Termination/ Change (Check all that apply):~~

- ~~☐ Change in Diagnosis~~
- ~~☐ Change in Symptoms~~
- ~~☐ Change in Service Activities~~
- ~~☐ Change in Treatment Recommendations~~
- ~~☐ Appropriate for Less Intensive Service~~
- ~~☐ Change in Service Staff~~
- ~~☐ Other~~ ____

~~List Service(s) Discontinued~~

~~List Service(s) Initiated~~

~~Service Change Instructions or Information:~~

______________________________________ ______________________

~~Signature/Credentials~~ ~~Date~~

~~Provider Discharge Summary~~

~~Purpose~~

~~When an individual is no longer receiving services from the agency, a Discharge Summary must be completed and placed in the individual's record. The Discharge Summary must be completed to summarize the services provided, the reason for the discharge from the provider agency, and any referrals made at the time of discharge.~~

~~Timeline~~

~~The effective date of the discharge must be documented.~~

~~Reason for Discharge~~

~~Indicate which category most appropriately describes the reason for discharge.~~

~~Referral Information~~

~~If the individual was referred to another provider or to other services, this should be indicated by selecting one or more categories that most appropriately describes the service or provider referral(s).~~

~~Instructions/Additional Information~~

~~If any instructions were provided to the individual or legal representative at the time of discharge, these must be described and individual receiving information must sign to acknowledge. Additional information specific to the discharge may be included.~~

~~If the individual participates in the ID/DD Waiver program, a copy of this form must be provided to the Individual's Support Coordinator within 5 days of discharge.~~

~~**Provider Discharge Summary**~~	
	~~**Name**~~
	~~**ID Number**~~
	~~**Date**~~ ______________________

~~**Effective Date of Discharge**~~ ______________________

~~**Reason For Discharge:**~~

- ❑ ~~Evaluation Only~~
- ❑ ~~Treatment Completed~~
- ❑ ~~Provider Terminated Treatment~~
- ❑ ~~Individual Referred Elsewhere~~
- ❑ ~~Other~~ ______________
- ❑ ~~Moved from service area~~
- ❑ ~~Deceased~~
- ❑ ~~No contact in 12 months~~
- ❑ ~~Individual requested discharge~~

~~**Referred To:**~~

- ❑ ~~DMH Behavioral Health Program~~
- ❑ ~~Other MS CMHC~~
- ❑ ~~DMH IDD Program~~
- ❑ ~~Private Psychiatric Hospital~~
- ❑ ~~Other MH Provider~~
- ❑ ~~Other IDD Provider~~
- ❑ ~~Other A&D Provider~~
- ❑ ~~Gen/Hospital/Other Health~~
- ❑ ~~Self~~
- ❑ ~~Family/Friend~~
- ❑ ~~School/Education~~
- ❑ ~~Employer/EAP~~
- ❑ ~~Police / Sheriff~~
- ❑ ~~Courts/Corrections~~
- ❑ ~~Probation/ Parole~~
- ❑ ~~Self Help Program~~
- ❑ ~~Voc Rehab/Job Placement~~
- ❑ ~~Licensed Personal Care Home~~
- ❑ ~~Private PRTF~~
- ❑ ~~Private ICF/IID~~
- ❑ ~~Other~~ ______________

~~**Discharge Instructions provided to**~~ ❑ ~~Individual~~ ❑ ~~Legal Representative~~

~~**Discharge Instructions/Additional Information:**~~

____

____

____

____

____

____

____ ______________

~~Individual/Legal Representative~~ ~~Date~~

____ ______________

~~Signature/Credentials~~ ~~Date~~

~~Section E~~
~~Day Service Programs~~

~~Acute Partial Hospitalization Services Summary Note~~

~~Individual Recovery Action Plan~~

~~Acute Partial Hospitalization Services Summary Note~~

~~Purpose~~

~~Documentation must be maintained when an individual receives Acute Partial Hospitalization Services. There must be documentation of medical supervision and follow along to include on-going evaluation of the medical status of the individual. Support services for families and significant others must be documented. Discharge criteria and follow-up planning must be documented.~~

~~Identifying Information~~

~~Record the name, record number, date of service and total amount of time the individual received the service.~~

~~Services~~

~~Indicate which services were provided during the day by checking the appropriate box, specify the time the service began and ended and list the name of the staff providing the service.~~

~~Therapeutic Activities Provided~~

~~List all activities the individual participated in during the day, specify the time the activity began and ended and list the name of the staff providing the service.~~

~~Daily Summary Note~~

~~The Master's level staff must summarize the progress of the individual receiving services in SAP format as it relates to the Individual Service Plan.~~

~~Timeline~~

~~APH Services must be documented daily with a summary note that records services provided.~~

~~Acute Partial Hospitalization Services Summary Note~~

~~Name~~ ______________________

~~ID Number~~ ______________________

~~Date~~ ______________________

~~Total Time~~

~~Services~~	~~Check~~	~~Time In~~	~~Time Out~~	~~Name of Service Provider~~
~~Medical Supervision~~				
~~Nursing~~				
~~Intensive Psychotherapy~~				
~~Individual Therapy~~				
~~Group Therapy~~				
~~Family Therapy~~				

~~Therapeutic Activities Provided~~

~~Activity~~	~~Time In~~	~~Time Out~~	~~Name of Activity Coordinator~~

~~Daily Summary Note~~

~~S~~

~~A~~

~~P~~

____

~~Signature/Credential~~

~~Individual Recovery Action Plan~~

~~Purpose~~

~~Individuals attending the PSR program must have a Wellness Recovery Action Plan (WRAP), Person-Centered Plan (PCP), or an IRAP (Individual Recovery Action Plan). Individuals must participate in the development of his/her plan.~~

~~The IRAP must be reviewed and revised when the problems or goals change or as needs of the individual change. At a minimum, the IRAP must be reviewed and revised/rewritten annually.~~

~~Definition of Quality of Life~~

~~Individuals must define what he/she considers quality of life.~~

~~Barriers to Quality of Life~~

~~List barriers which prevent the individual from achieving the quality of life he/she desires.~~

~~Goal~~

~~List the goals that are the focus of PSR services.~~

~~Action Step to Obtain Goal~~

~~List the action steps that need to be accomplished in order to achieve the goal(s). Address the identification and integration of natural supports to connect to the community and the utilization of formal and informal resources to support goals and desired outcomes.~~

~~Desired Outcome~~

~~List the individual's desired outcomes.~~

~~Date Goal Achieved~~

~~Document the date the goal was achieved.~~

~~Individual Recovery Action Plan~~

~~Name~~ ____________________

~~ID Number~~ ____________________

~~Date~~ ____________________

~~Definition of Quality of Life~~		
~~Barriers to Quality of Life~~		
~~Goals~~		~~Dates Achieved~~
~~Action Steps~~		

~~**Linked and Followed up to Resources In Community**~~	~~Goal 1~~	
	~~Goal 2~~	
	~~Goal 3~~	
	~~Goal 4~~	
	~~Goal 5~~	

~~**PSR Staff:**~~ ______________________ ~~**Date:**~~	~~**Individual Receiving Services:**~~ ______________________ ~~**Date:**~~

~~Section F~~
~~Mental Health Services~~

~~Adult Making A Plan (AMAP) Case Summary~~

~~Adult Making A Plan (AMAP) Monthly Reporting~~

~~Crisis Stabilization Services Daily Note~~

~~Adult Pre-Evaluation Screening~~

~~Youth Pre-Evaluation Screening~~

~~Violence Risk Assessment for Certified Holding Facility~~

~~Suicide Risk Assessment for Certified Holding Facility~~

~~Adult Making A Plan (AMAP) Case Summary~~

~~Purpose~~

~~Adult Making a Plan (AMAP) Teams address the needs of adults with serious mental illness who require services from multiple agencies and multiple program systems due to multiple/frequent in-patient treatment admissions or commitments. The purpose of the AMAP Team is to develop and implement new and different systems of wrap-around support in order to treat individuals in the community rather than an institutional setting. All Community Mental Health Centers must document participation in at least one AMAP Team in their region.~~

~~Documentation~~

~~If DMH funds are utilized to assist individuals referred to the AMAP Team, all questions in all sections of the Case Summary form must be answered in as much detail as possible in order to justify the need for AMAP Team intervention.~~

~~Timeline~~

~~The AMAP Case Summary form must be completed, attached to the Mobile Crisis Response Team (M-CeRT) cash request, and submitted to the Department of Mental Health by the 15th of the following month.~~

~~AMAP Team~~ **~~Case Summary Form~~**	~~Name:~~ ______________________________ ~~Date of Review~~ ___________________

~~**Why was this individual referred to the AMAP Team?** *(How many inpatient tx/over what period of time)*~~

~~**Why was this individual considered to be at-risk?**~~

~~**Recommendations of the team (include how they differ from past interventions) :**~~

~~**If DMH funds will be used for this individual, indicate estimated amounts for each recommended service/support agreed upon by the team.**~~

~~**If DMH funds will be used for this individual, how will the use of these funds maintain this individual in his/her home and community? How will the service/support continue after the use of DMH funds?**~~

~~**Signature of AMAP Team Coordinator**~~ ____

~~Adult Making A Plan (AMAP) Monthly Report~~

~~Purpose~~

~~Adult Making a Plan (AMAP) Teams address the needs of adults with serious mental illness who require services from multiple agencies and multiple program systems due to multiple/frequent in-patient treatment admissions or commitments. The purpose of the AMAP Team is to develop and implement new and different systems of wrap-around support in order to treat individuals in the community rather than an institutional setting.~~

~~Documentation~~

~~Document the county where the AMAP meeting was held and the month the meeting took place. Document the number of each staff representing the agencies involved with the AMAP Team. Have each team member sign the attendance log and write the name of their agency on the same line.~~

~~Timeline~~

~~The AMAP Monthly Reporting form must be completed, attached to the Mobile Crisis Response Team (M-CeRT) cash request, and submitted to the Department of Mental Health by the 15th of the following month.~~

~~AMAP Team~~ **~~Monthly Reporting~~**	**~~County~~** ______________________ **~~Month~~** ______________________

~~Monthly Reporting Forms must be submitted to the Department of Mental Health by the 15th of each month. Case summary forms, for each adult reviewed, must be submitted with the monthly reporting form. Cash requests will not be processed without this information.~~

~~Referral Information~~

~~1. Number of cases reviewed~~ _____

~~2. Number of follow-ups from previous month~~ _____

~~3. Number of referrals from:~~

_____ ~~Mental Health Center in your county~~ _____ ~~Mental Health Center Region-Wide~~

_____ ~~Mental Health Center (other Region)~~ _____ ~~Chancery Court/Clerk~~

_____ ~~MDMH State Hospital~~ _____ ~~Sheriff's Department~~

_____ ~~Crisis Stabilization Unit~~ _____ ~~Police Department~~

_____ ~~Behavioral/Mental Health Court~~ _____ ~~Family Member(s)~~

_____ ~~Other~~

~~AMAP Team Member Participation~~

~~Please indicate, using a checkmark, which of the following agencies that were represented at your AMAP Team Meeting(s) for the month.~~

_____ ~~Community Mental Health Center~~ _____ ~~MDMH State Hospital~~

_____ ~~Chancery Court~~ _____ ~~Crisis Stabilization Unit~~

_____ ~~Sheriff's Department~~ _____ ~~Police Department~~

_____ ~~Families~~ _____ ~~Individual Receiving Services~~

_____ ~~NAMI~~ _____ ~~Other *please identify~~

~~AMAP Team Member Participation~~

~~Attendance Log~~

~~Team Member~~ ~~Agency Represented~~

~~Crisis Stabilization Services~~
~~Daily Activity/Daily Progress Summary Note~~

~~Purpose~~
~~Documentation must be maintained when an individual receives Crisis Stabilization Services. Each therapeutic activity must be documented along with a summary of progress for each day the individual receives services. All psychiatric care, nursing services and mental health therapy will be documented in the Individualized Progress Note format.~~

~~Identifying Information~~
~~Record the name, record number, date of service and total amount of time the individual received the service.~~

~~Therapeutic Activities Provided~~
~~Indicate the nature of the therapeutic activities being provided, specify the time the activity began and ended and list the name of the staff leading the services.~~

~~Daily Summary Note~~
~~A Master's level therapist must summarize the progress of the individual receiving services as it relates to the Individual Service Plan.~~

~~Timeline~~
~~Crisis Stabilization Services must be documented daily with a summary note that records services provided.~~

~~Crisis Stabilization Services (i.e. counseling, therapy, recreational, education, and social/interpersonal activities) can be provided seven (7) days per week but must at a minimum be;~~

- ~~a. Provided five (5) days per week.~~
- ~~b. Provided five (5) hours per day.~~
- ~~c. Provided two (2) hours per day for children/youth enrolled and attending school full time.~~

~~Crisis Stabilization Services Daily Activity/Daily Summary Note~~

~~Name~~ ____________________

~~ID Number~~ ____________________

~~Date~~ ____________________

~~Total Time~~

~~Therapeutic Activities Provided~~

~~Activity~~	~~Time In~~	~~Time Out~~	~~Name of Activity Coordinator~~

~~Daily Summary Note~~

____

~~Signature/Credential~~

~~Youth and Adult Pre-Evaluation Screening~~

~~Purpose~~
~~The Pre-Evaluation Screening is required under Mississippi Civil Commitment Statutes. The Pre-Evaluation Screening must take place prior to the Civil Commitment Exam and can only be completed by staff from a Community Mental Health Center. The Pre-Evaluation Screening is used to gather information pertaining to an individual to be used by the Chancery, Family and/or Youth Court in determining the need for civil commitment.~~

~~Timeline~~
~~The Pre-Evaluation Screening must take place within 48 hours after an affidavit has been filed in Chancery, Family and/or Youth Court.~~

~~General~~
~~The Pre-Evaluation Screening must be filled out as completely as possible. Do not leave any spaces blank. If you are unable to gather certain information then make a notation in that space. Information can be gathered from informants, the individual and the individual's record.~~

~~The Adult Pre-Evaluation is to be used with individuals 18 years and older. The Youth Pre-Evaluation is to be used with individuals 14 – 17 years of age.~~

~~Once the Pre-Evaluation Screening is completed, recommend to the court if a Civil Commitment Exam should take place. If you recommend that the Civil Commitment Exam does not need to take place, indicate on the form why and list appropriate referrals that have been made or should be made. Include any additional comments that you think are pertinent to the court.~~

~~A copy of the completed form must be kept in the individual's record.~~

~~Signature~~
~~The staff person completing the Pre-Evaluation Screening must sign the report to include credentials.~~

~~Adult Pre-Evaluation~~

~~Date:~~ ~~Time In:~~ ~~Time Out:~~	~~Interview Location:~~
~~Individuals Present:~~	
~~Interpretative Aids/Assisted Devices:~~	~~Pending Felony Charges: ☐ Yes ☐ No~~
~~Case Number:~~	~~CMHC Region:~~
~~In the ______ court of ______ County~~	~~Voluntary CSU Admission Sought : ☐ Yes ☐ No~~
~~Mobile Crisis Involvement : ☐ Yes ☐ No~~	

~~Information from this interview will be reported on a standardized form and submitted to the chancery court and civil commitment examiners. You have the right to refuse to participate. Other sources of information including a review of your legal medical records and interviews with family member and the affiant requesting commitment will be included in this report.~~

~~**Respondent Demographics**~~		
~~Name:~~	~~DOB: 0T~~	~~Age: ______ Gender: ______ Race:~~
~~Social Sec #: ______ Medicaid #: ______ Medicare#:~~		
~~Home Address:~~		~~Phone Number:~~
~~Respondent resides with minor children: ☐ Yes ☐ No~~		~~Name & Ages of Children:~~
~~Respondent has visitation rights to minor children: ☐ Yes ☐ No~~		
~~Respondent has legal guardian/conservator: ☐ Yes ☐ No~~		
		~~Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other~~

~~**Affiant Demographics**~~	
~~Affiant Name:~~	~~Relation of Respondent:~~
~~Phone Number:~~	~~Home Address:~~
	~~Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other~~

~~**Respondent Psychosocial Information**~~	
~~Current Living: ☐Alone ☐Family/Friends ☐Assisted Living ☐Homeless ☐Other/Describe:~~	
~~Housing: ______ Dwelling:~~	~~Home Address:~~
~~Employed: ☐ Yes ☐ No ______ Employer/Position:~~	~~Length of Job:~~
~~If unemployed (most recent job?):~~	~~Highest Level of Education Completed:~~
~~Religious Preference or Practice:~~	
	~~Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other~~

~~**Psychiatric History**~~		
~~Current Psychotropic Medications:~~	~~Dosage & Date/Time Last Taken:~~	~~Is the medication helpful or problematic:~~
~~Psychiatric Hospitalizations:~~	~~Locations/Dates:~~	
~~Outpatient Treatments:~~	~~Locations/Dates:~~	
~~Psychological Testing:~~	~~Provider/Dates:~~	
	~~Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other~~	

~~**Medical Status & Treatment History**~~		
~~Current Medications (not listed above):~~	~~Dosage & Date/Time Last Taken:~~	~~Is the medication helpful or problematic:~~
~~Known Medication Allergies:~~		
~~Currently Under Physician Care For:~~	~~Physician's Name:~~	
~~Conditions Treated In The Past:~~	~~Provider/Dates:~~	
~~Medical Hospitalization History:~~	~~Physical Disabilities:~~	
~~Current Communicable Diseases:~~ ~~☐ HIV/AIDS ☐Hepatitis A ☐Hepatitis B ☐Hepatitis C ☐TB(Tuberculosis)~~ ~~☐ MRSA ☐Influenza ☐Head Lice ☐Scabies ☐Body Lice ☐STIs ☐Other~~		
~~**Currently Pregnant:** ☐ Yes ☐ No~~		
~~Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other~~		

~~**Developmental Disability**~~	
~~History of Special Education Ruling: ☐ Yes ☐ No~~	~~If yes, describe:~~
~~Documented IQ below 70: ☐ Yes ☐ No~~	~~If yes, describe:~~
~~Documented sub-average intellectual functioning before age 18: ☐ Yes ☐ No~~	~~If yes, describe:~~
~~Documented Adaptive Functioning Deficits: ☐ Yes ☐ No~~	~~If yes, describe:~~
~~Specific Observed Adaptive Functioning Deficits:~~	
~~Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other~~	

~~**Mental State Exam**~~
~~Oriented to Date: Time: Place:~~ ~~*Cue for three words (provide words)~~
~~President:~~
~~Counting Response:~~
~~Word Recall:~~
~~Completed Written Command: ☐ Yes ☐ No If no, describe:~~
~~What do you understand the reason for our meeting today to be?~~
~~Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other~~

~~**Psychiatric Symptoms Past Month**~~								
~~**Respondent(R) Informant(I)**~~								
~~**Depressive Symptoms**~~	~~**R**~~	~~**I**~~	~~**Anxiety Symptoms**~~	~~**R**~~	~~**I**~~	~~**Somatic Symptoms**~~	~~**R**~~	~~**I**~~
~~☐ Depressed mood most of the day~~	~~☐~~	~~☐~~	~~☐ Worry~~	~~☐~~	~~☐~~	~~☐ Headaches~~	~~☐~~	~~☐~~
~~☐ Lack of Interest/Pleasure~~	~~☐~~	~~☐~~	~~☐ Restlessness~~	~~☐~~	~~☐~~	~~☐ Chest Discomfort/Pain~~	~~☐~~	~~☐~~
~~☐ Appetite Change or Sig Weight Change~~	~~☐~~	~~☐~~	~~☐ Easily Fatigued~~	~~☐~~	~~☐~~	~~☐ Faintness~~	~~☐~~	~~☐~~
~~☐ Insomnia (Difficulty Falling Asleep)~~	~~☐~~	~~☐~~	~~☐ Irritability~~	~~☐~~	~~☐~~	~~☐ Hot or Cold Flashes~~	~~☐~~	~~☐~~
~~☐ Feelings of Worthlessness~~	~~☐~~	~~☐~~	~~☐ Muscle Tension~~	~~☐~~	~~☐~~	~~☐ Stomach Aches/Pains~~	~~☐~~	~~☐~~
~~☐ Fatigue or Loss of Energy~~	~~☐~~	~~☐~~	~~☐ Difficulty Concentrating~~	~~☐~~	~~☐~~	~~☐ Heart Palpitations~~	~~☐~~	~~☐~~
~~☐ Diminished Concentration~~	~~☐~~	~~☐~~	~~☐ Sleep Disturbance~~	~~☐~~	~~☐~~	~~☐ Dizziness or Vertigo~~	~~☐~~	~~☐~~

Depressive Symptoms	R	I	Anxiety Symptoms	R	I	Somatic Symptoms	R	I
☐ Indecisiveness	☐	☐	☐ Other	☐	☐	☐ Shaking/Trembling	☐	☐
☐ Hypersomnia (Sleeping Excessively)	☐	☐				☐ Tingling in hands or feet	☐	☐
☐ Recurrent Thoughts of Death	☐	☐				☐ Excessive Sweating	☐	☐
☐ Motor Retardation	☐	☐				☐ Other	☐	☐
☐ Motor Agitation	☐	☐						
☐ Feelings of Hopelessness	☐	☐						
☐ Other	☐	☐						

Psychiatric Symptoms Past Month

Respondent(R) Informant(I)

Mania & Hypomania Symptoms	R	I		R	I
☐ At least 1 week	☐	☐	☐ More talkative than usual	☐	☐
☐ 4 consecutive days < weeks	☐	☐	☐ Excessive involvement in activities with high potential for painful consequences	☐	☐
☐ Flight of ideas/racing thoughts	☐	☐	☐ Distractibility	☐	☐
☐ Decreased need for sleep	☐	☐	Persistent elevated, or irritable mood and significant increases in goal directed activity ☐Yes ☐No	☐	☐
☐ Increased self-esteem of Grandiosity	☐	☐			

Thought Disorder Symptoms	R	I		R	I
☐ Hallucinations	☐	☐	☐ Absence of emotions	☐	☐
☐ Auditory ☐Visual ☐Olfactory	☐	☐	☐ Absence of speech	☐	☐
☐ Tactile ☐Gustatory	☐	☐	☐ Absence of movement	☐	☐
Specific Hallucinations:	☐	☐	☐ Lack of Hygiene	☐	☐
☐ Delusions	☐	☐	☐ Lack of eating/feeding	☐	☐
☐Persecutory ☐Grandiose ☐Paranoid ☐ Other	☐	☐			
Specific Delusions:					
Obsessive Compulsive Symptoms					
Obsessive Thoughts ☐Yes ☐No	☐	☐	Obsessive Thoughts ☐Yes ☐No	☐	☐
Severity: ☐Mild ☐Moderate ☐Severe	☐	☐	Severity: ☐Mild ☐Moderate ☐Severe	☐	☐
Specific Obsessions:	☐	☐	Specific Obsessions:	☐	☐

TRAUMA HISTORY

Trauma Exposure ☐Yes ☐No (type/approx. Date)				
Trauma Triggers:				
Environmental	☐ Crowding ☐ Leaving bedroom door open	☐ Room checks ☐ Dark room	☐ Confusing signs ☐ Too hot or too cold	☐ Slamming doors ☐ Noise
Interpersonal	☐ Lack of privacy ☐ Confined spaces ☐ Being stared at ☐ Being approached by women	☐ Being approached by men or women ☐ Being touched ☐ Being ignored ☐ Being Teased/picked on ☐ Tall or large people	☐ Arguments ☐ People too close ☐ Feeling pressured ☐ People focusing on my symptoms	☐ People Yelling ☐ Contact with Family ☐ Being ordered to do something ☐ Smells
Other Triggers	☐ Taste ☐ Time of Day	☐ Sounds ☐ Sights	☐ Sensations/textures	☐ Wringing hands
Warning Signs of Emotional escalations	☐ Heart Pounding ☐ Clenching teeth ☐Bouncing legs ☐ Sweating	☐ Shortness of Breath ☐ Flushed/red face ☐Singing ☐ Rocking	☐ Breathing Hard ☐ Crying ☐Can't sit still ☐ Pacing	☐ Wringing hands ☐ Clenching fists ☐ Cursing/swearing ☐ Giggling
Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other				

~~Suicide Assessment~~

~~Prior Attempts:~~	~~Friend or Family Member Completed Suicide:~~
~~Approximate Date:~~	~~Approximate Date:~~
~~Method of attempt:~~	~~Method of suicide:~~
	~~Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other~~

~~Behaviors Exhibited by Respondent~~

~~History or Present Danger to Others ☐ Yes ☐ No~~ ~~*(If Yes, mark appropriate statement(s) below)*~~

~~☐ Thoughts of suicide~~	~~☐ Threats of suicide~~	~~☐ Plan for Suicide~~	~~☐ Pre-occupation with death~~
~~☐ Suicide gesture~~	~~☐ Suicide attempts~~	~~☐ Family history of suicide~~	~~☐ Self-mutilation~~
~~☐ Inability to care for self~~	~~☐ High risk behavior~~	~~☐ Provoking harm to self from others~~	

~~☐ Other~~

~~Describe:~~

~~Violence Risk Assessment~~

~~Current thoughts about harming another person ☐ Yes ☐ No~~
~~If Yes, whom:~~
~~If yes, how long have you had these thoughts~~
~~If yes, specific plan:~~
~~Access to means to carry out plan:~~
~~Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other~~

~~Violence Risk Factors Present~~

~~Present~~	~~Unknown~~		~~Present~~	~~Unknown~~	
☐	☐	~~Male Gender~~	☐	☐	~~Substance Abuse~~
☐	☐	~~Suspiciousness/Perception of hidden threat~~	☐	☐	~~Comorbid MI & Substance Use Dx~~
☐	☐	~~Early offense history~~	☐	☐	~~Anger~~
☐	☐	~~Psychopathy~~	☐	☐	~~Antisocial Personality Diagnosis~~
☐	☐	~~Violent Fantasies~~	~~Frequency, type, recency~~		
☐	☐	~~Previous violence against other people~~	~~Frequency, severity, type~~		
☐	☐	~~Childhood physical abuse~~	~~Frequency, severity~~		
			~~Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other~~		

~~Substance Use~~

~~Do you currently use?~~

	~~Past Use~~	~~Amount~~	~~Frequency~~	~~Age of Initiation~~
~~Alcohol~~				
~~Marijuana~~				
~~Opioids~~				
~~Amphetamines~~				
~~Hallucinogenic~~				
~~Prescription Medication~~				
~~Over the counter medication~~				

~~History of legal charges related to substance use? ☐ Yes ☐ No~~	~~Describe:~~
	~~Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other~~

~~Physical Appearance~~

	~~Attire~~	~~Hair~~	~~Nails~~	~~Skin~~	
☐ ~~Glasses~~	☐ ~~Appropriate for occasion~~	☐ ~~Clean~~	☐ ~~Clean~~	☐ ~~Clean~~	☐ ~~Bruised~~
☐ ~~Contacts~~	☐ ~~Appropriate for weather~~	☐ ~~Dirty~~	☐ ~~Dirty~~	☐ ~~Dirty~~	☐ ~~Cuts/Scrapes~~
☐ ~~Hearing Aids~~	☐ ~~Clean~~	☐ ~~Disheveled~~	☐	☐ ~~Tattoos Describe:~~	
	☐ ~~Dirty~~	☐ ~~Styled~~			
	☐ ~~Torn/worn through~~		☐	☐ ~~Sores~~	
	☐ ~~Other~~		☐		

~~**Teeth**~~	~~Unusual alterations or distinguishing features:~~
☐ ~~Clean~~	
☐ ~~Dirty~~	
☐ ~~Decay~~	
☐ ~~Missing~~	

~~Source of Information:~~ ☐~~Respondent~~ ☐~~Affiant~~ ☐~~Chart Review~~ ☐~~Other~~

~~Behavioral Observations~~

~~**Motor Activity**~~				
~~Diminished~~	~~Normal~~	~~Excessive~~	~~Unusual~~	
☐ ~~Frozen~~	☐ ~~Purposeful~~	☐ ~~Restless~~	☐ ~~Other~~	
☐ ~~Catatonic~~	☐ ~~Coordinated~~	☐ ~~Squirming~~		
☐ ~~Almost motionless~~	☐ ~~Other~~	☐ ~~Fidgety~~		
☐ ~~Little animation~~		☐ ~~Constant movement~~		
☐ ~~Psychomotor retardation~~		☐ ~~Hyperactive~~		
☐ ~~Slowed reaction time~~		☐ ~~Other~~		
☐ ~~Other~~				
~~**Speech**~~				
~~Slowed~~	~~Normal~~	~~Pressured~~	~~Verbose~~	~~Unusual~~
☐ ~~Minimal response~~	☐ ~~Initiates~~	☐ ~~Excessively wordy~~	☐ ~~Over productive~~	☐
☐ ~~Unspontaneous~~	☐ ~~Alert/responsive~~	☐ ~~Expansive~~	☐ ~~Long winded~~	
☐ ~~Sluggish~~	☐ ~~Productive~~	☐ ~~Rapid~~	☐ ~~Non stop~~	
☐ ~~Paucity~~	☐ ~~Animated~~	☐ ~~Fast~~	☐ ~~Frequent run ons~~	
☐ ~~Impoverished~~	☐ ~~Spontaneous~~	☐ ~~Rushed~~	☐ ~~Flight of ideas~~	
☐ ~~Single word answers~~	☐ ~~Smooth~~	☐ ~~Other~~	☐ ~~Hyper verbal~~	
☐ ~~Other~~	☐ ~~Other~~		☐ ~~Other~~	
~~**Thought Process**~~				
~~Attention~~	~~Insight~~	~~Preoccupations~~		
☐ ~~Normal~~	☐ ~~Good~~	☐ ~~Somatics~~	☐ ~~Self~~	
☐ ~~Unengaged~~	☐ ~~Fair~~	☐ ~~Children~~	☐ ~~Finances~~	
☐ ~~Distractible~~	☐ ~~Poor~~	☐ ~~Spouse/Sig Other~~	☐ ~~Other~~	
☐ ~~Hyper vigilant~~	☐ ~~No insight~~	☐ ~~Job~~		
☐ ~~Hyper focused~~				

~~Source of Information:~~ ☐~~Respondent~~ ☐~~Affiant~~ ☐~~Chart Review~~ ☐~~Other~~

~~**Affect**~~				
☐ ~~Flat~~	☐ ~~Blunted~~	☐ ~~Constricted~~	☐ ~~Normal~~	☐ ~~Broad~~

~~Facial Expression~~				
~~☐ Vacant~~	~~☐ Blank~~	~~☐ Strained~~	~~☐ Pained~~	~~☐ Grimacing~~
~~☐ Smiling~~	~~☐ Other~~			

~~Summary & Recommendations~~

~~Based on the data gathered for the current Pre Evaluation Screening:~~

~~☐ It is **NOT** recommended that this respondent receive a civil commitment exam.~~

1) ~~Current available information indicates that present symptomatology is due to~~

   ~~☐ Dementia ☐Intellectual/Developmental Disability ☐ Epilepsy ☐Chemical Dependency ☐Mental Illness~~

2) ~~The following referrals for appropriate evaluation or treatment have been provided:~~
   ~~a.~~

   ~~b.~~

   ~~c.~~

~~☐ It **IS** recommended that this respondent receive a civil commitment exam. Based on the data available for the current Pre Screening Evaluation the following symptomatology cannot be managed/treated in a less restrictive environment:~~

~~1)~~

~~2)~~

~~3)~~

~~4)~~

~~Comments:~~

____

~~Signature-Credentials~~

~~Youth Pre-Evaluation~~

~~**Date:** Click for date **Time In:** 0T **Time Out:** 0T~~	~~**Interview Location: 0T**~~
~~**Individuals Present:** 0T~~	
~~**Interpretative Aids/Assisted Devices:0T**~~	~~**Pending Felony Charges:** ☐ Yes ☐ No~~
~~**Case Number:**~~	~~**CMHC Region:** 0T~~
~~**In the** Court **court of County**~~	~~**Voluntary CSU Admission Sought:** ☐ Yes ☐ No~~
~~**Mobile Crisis Involvement**: ☐ Yes ☐ No~~	

~~Information from this interview will be reported on a standardized form and submitted to the chancery court and civil commitment examiners. You have the right to refuse to participate. Other sources of information including a review of your legal medical records and interviews with family member and the affiant requesting commitment will be included in this report.~~

~~**Respondent Demographics**~~		
~~**Name:** 0T~~	~~**DOB:** 0T~~	~~**Age: Gender: Race:**~~
~~**Social Sec #:** e.g. 123-12-1234~~	~~**Medicaid #:**~~	~~**Medicare#:**~~
~~**Home Address: 0T**~~		~~**Phone Number:** 0T~~
~~**Does the respondent have a legal guardian or conservator:** ☐ Yes ☐ No~~		
~~**Guardian/Conservator Contact Information** 0T~~		
		~~**Source of Information:** ☐Respondent ☐Affiant ☐Chart Review ☐Other~~

~~**Affiant Demographics**~~	
~~**Affiant Name:** 0T~~	~~**Relation of Respondent:**~~
~~**Phone Number:** 0T~~	~~**Home Address: 0T**~~
	~~**Source of Information:** ☐Respondent ☐Affiant ☐Chart Review ☐Other~~

~~**Respondent Psychosocial Information**~~	
~~**Current Living:** 0T~~	
~~**Current Grade in School:**~~	~~**Name of School: 0T**~~
~~**History of IEP or 504C:** ☐ Yes ☐ No **Date of most recent IEP or 504C:** 0T~~	
~~**Juvenile Justice Involvement:** ☐ Yes ☐ No~~	~~**Describe: 0T**~~
	~~**Source of Information:** ☐Respondent ☐Affiant ☐Chart Review ☐Other~~

~~**Psychiatric History**~~		
~~**Current Psychotropic Medications:** 0T~~	~~**Dosage & Date/Time Last Taken:** 0T~~	~~**Is the medication helpful or problematic:** 0T~~
~~**Psychiatric Hospitalizations:** 0T~~	~~**Locations/Dates:** Enter Location and Date~~	
~~**Outpatient Treatments**: 0T~~	~~**Locations/Dates: 0T**~~	
~~**Psychological Testing: 0T**~~	~~**Provider/Dates:**~~	
	~~**Source of Information:** ☐Respondent ☐Affiant ☐Chart Review ☐Other~~	

~~Medical Status & Treatment History~~		
~~**Current Medications (not listed above):** 0T~~	~~**Dosage & Date/Time Last Taken:** 0T~~	~~**Is the medication helpful or problematic:** 0T~~
~~**Known Medication Allergies:**0T~~		
~~**Currently Under Physician Care For**: 0T~~	~~**Physician's Name: 0T**~~	
~~**Conditions Treated In The Past: 0T**~~	~~**Provider/Dates:**~~	
~~**Medical Hospitalization History:**~~	~~**Physical Disabilities:**~~	
~~**Current Communicable Diseases:**~~ ~~☐ HIV/AIDS ☐Hepatitis A ☐Hepatitis B ☐Hepatitis C ☐TB(Tuberculosis)~~ ~~☐ MRSA ☐Influenza ☐Head Lice ☐Scabies ☐Body Lice ☐STIs ☐Other~~		
~~**Currently Pregnant:** ☐ Yes ☐ No~~		
~~**Source of Information:** ☐Respondent ☐Affiant ☐Chart Review ☐Other~~		

~~Developmental Disability~~	
~~**Pregnancy/Delivery Complications:** ☐ Yes ☐ No~~	~~**Describe:**~~
~~**Met Developmental Milestones On Time:**~~ ~~Walked ☐ Talked ☐ Crawled ☐ Toilet Trained ☐ Feeding ☐~~	~~**If no, describe:** escribe~~
~~**History of Special Education Ruling:** ☐ Yes ☐ No~~	~~**If yes, describe:** Describe~~
~~**Documented IQ below 70:** ☐ Yes ☐ No~~	~~**If yes, describe:** Describe~~
~~**Documented sub-average intellectual functioning before age 18:** ☐ Yes ☐ No~~	~~**If yes, describe:** Describe~~
~~**Documented Adaptive Functioning Deficits:** ☐ Yes ☐ No~~	~~**If yes, describe:** Describe~~
~~**Specific Observed Adaptive Functioning Deficits:** 0T~~	
~~**Source of Information:** ☐Respondent ☐Affiant ☐Chart Review ☐Other~~	

~~Mental State Exam~~
~~**Oriented to Date:** select date **Time:** Enter Time **Place:0T**~~ ~~*Cue for three words (provide words)~~
~~**President:** Enter Response~~
~~**Counting Response:** 0T~~
~~**Word Recall:** 0T 0T 0T~~
~~**Completed Written Command:** ☐ Yes ☐ No **If no, describe:** 0T~~
~~**What do you understand the reason for our meeting today to be?** 0T~~
~~**Source of Information:** ☐Respondent ☐Affiant ☐Chart Review ☐Other~~

~~Psychiatric Symptoms Past Month~~								
~~Respondent(R) Informant(I)~~								
~~**Mood Symptoms**~~	~~**R**~~	~~**I**~~	~~**Mood Symptoms**~~	~~**R**~~	~~**I**~~	~~**Behavioral Symptoms**~~	~~**R**~~	~~**I**~~
~~☐ Depressed mood/Appears Sad~~	☐	☐	~~☐ Dizzy~~	☐	☐	~~☐ Attempts to " Annoy" Others~~	☐	☐
~~☐ Enjoys Very Little~~	☐	☐	~~☐ Shaking/Trembling~~	☐	☐	~~☐ Defies Requests~~	☐	☐
~~☐ Cries Frequently~~	☐	☐	~~☐ Excessive Sweating~~	☐	☐	~~☐ Angry & Resentful~~	☐	☐
~~☐ Decrease in Appetite~~	☐	☐	~~☐ Shortness of Breath~~	☐	☐	~~☐ Sullen~~	☐	☐
~~☐ Increase in Appetite~~	☐	☐	~~☐ Tingling in Hands or Feet~~	☐	☐	~~☐ Irritable~~	☐	☐

Mood Symptoms continues	R	I	Mood Symptoms continues	R	I	Behavioral Symptoms continues	R	I
☐ Fatigued or Underactive (without reason)	☐	☐	☐ Headache	☐	☐	☐ Tantrums	☐	☐
☐ Difficulty Sleeping	☐	☐	**Behavioral Symptoms**	**R**	**I**	☐ Lying	☐	☐
☐ Nightmares/Nigh Terrors	☐	☐	☐ Impulsive	☐	☐	☐ Cheating	☐	☐
☐ Withdrawn From Peers	☐	☐	☐ Fails to Finish Tasks	☐	☐	☐ Steals	☐	☐
☐ Bullied or Rejected by Peers	☐	☐	☐ Talks Excessively	☐	☐	☐ Physically Harms People	☐	☐
☐ Engages in Self Harm	☐	☐	☐ Loud	☐	☐	☐ Physically Harms Animals	☐	☐
☐ Talks About Killing Self Wishes to die	☐	☐	☐ Blurts Words/Interrupts	☐	☐	☐ Destroys Property	☐	☐
☐ Clings to Adults/Dependent	☐	☐	☐ Difficulty Sitting Still, Restless	☐	☐	☐ Sets Fires	☐	☐
☐ Fears Specific Situations or Objects Describe:	☐	☐	☐ Fidgets	☐	☐	☐ Threatens Others	☐	☐
☐ Reports Fearing School	☐	☐	☐ Easily Distracted	☐	☐	☐ Physical Fights With Peers	☐	☐
☐ Worries	☐	☐	☐ Disorganized	☐	☐	☐ Skips School	☐	☐
☐ Tense	☐	☐	☐ Forgetful/Misplaces Belongings	☐	☐	☐ Used a Weapon	☐	☐
☐ Stomach Aches or Pains	☐	☐	☐ Loses Temper Frequently	☐	☐	☐ Delinquent Peers	☐	☐
☐ Heart Palpitations	☐	☐	☐ Argues with Adults ☐ Home ☐ School	☐	☐			

Psychiatric Symptoms Past Month

Respondent(R) Informant(I)

Thought Disorder Symptoms	R	I		R	I
☐ Hallucinations	☐	☐	☐ Absence of emotions	☐	☐
☐ Auditory ☐ Visual ☐ Olfactory	☐	☐	☐ Absence of speech	☐	☐
☐ Tactile ☐Gustatory	☐	☐	☐ Absence of movement	☐	☐
Specific Hallucinations: 0T	☐	☐	☐ Lack of Hygiene	☐	☐
☐ Delusions	☐	☐	☐ Lack of eating/feeding	☐	☐
☐ Persecutory ☐Grandiose ☐ Paranoid ☐ Other	☐	☐			
Specific Delusions: 0T					
Obsessive Compulsive Symptoms					
Obsessive Thoughts ☐Yes ☐ No	☐	☐	Obsessive Thoughts ☐Yes ☐ No	☐	☐
Severity: ☐Mild ☐Moderate ☐Severe	☐	☐	Severity: ☐Mild ☐Moderate ☐Severe	☐	☐
Specific Obsessions:0T	☐	☐	Specific Obsessions:0T	☐	☐

TRAUMA HISTORY				
Trauma Exposure ☐Yes ☐No (type/approx. Date) Click here to enter text.				
Trauma Triggers:				
Environmental	☐ Crowding ☐ Leaving bedroom door open	☐ Room checks ☐ Dark room	☐ Confusing signs ☐ Too hot or too cold	☐ Slamming doors ☐ Noise
Interpersonal	☐ Lack of privacy	☐ Being approached by	☐ Arguments	☐ People Yelling

		~~men or women~~		
	~~☐ Confined spaces~~	~~☐ Being touched~~	~~☐ People too close~~	~~☒Contact with Family~~
	~~☐ Being stared at~~	~~☐ Being ignored~~	~~☐ Feeling pressured~~	~~☐ Being ordered to do something~~
	~~☐ Being approached by women~~	~~☐ Being Teased/picked on~~	~~☐ Tall or large people~~	~~☐ Smells~~
				~~☐ People focusing on my symptoms~~
~~**Other Triggers**~~	~~☐ Taste ☐ Time of Day~~	~~☐ Sounds ☐ Sights~~	~~☐ Sensations/textures~~	~~☐ Wringing hands~~
~~**Warning Signs of Emotional escalations**~~	~~☐ Heart Pounding~~	~~☐ Shortness of Breath~~	~~☐ Breathing Hard~~	~~☐ Wringing hands~~
	~~☐ Clenching teeth~~	~~☐ Flushed/red face~~	~~☐ Crying~~	~~☐ Clenching fists~~
	~~☐ Bouncing legs~~	~~☐ Singing~~	~~☐ Can't sit still~~	~~☐ Cursing/swearing~~
	~~☐ Sweating~~	~~☐ Rocking~~	~~☐ Pacing~~	~~☐ Giggling~~
~~**Source of Information:** ☐Respondent ☐Affiant ☐Chart Review ☐Other~~				

~~**Suicide Assessment**~~	
~~**Prior Attempts:** 0T~~	~~**Friend or Family Member Completed Suicide:** 0T~~
~~**Approximate Date:** 0T~~	~~**Approximate Date:** 0T~~
~~**Method of attempt:** 0T~~	~~**Method of suicide:** 0T~~
	~~**Source of Information:** ☐Respondent ☐Affiant ☐Chart Review ☐Other~~

~~Behaviors Exhibited by Respondent~~

~~**History or Present Danger to Others** ☐ Yes ☐ No *(If Yes, mark appropriate statement(s) below)*~~

~~☐ Thoughts of suicide~~	~~☐ Threats of suicide~~	~~☐ Plan for Suicide~~	~~☐ Pre-occupation with death~~
~~☐ Suicide gesture~~	~~☐ Suicide attempts~~	~~☐ Family history of suicide~~	~~☐ Self-mutilation~~
~~☐ Inability to care for self~~	~~☐ High risk behavior~~	~~☐ Provoking harm to self from others~~	
~~☐ Other~~			
~~Describe:~~			

~~Violence Risk Assessment~~

~~**Current thoughts about harming another person** ☐ Yes ☐ No~~

~~**If Yes, whom:** 0T~~

~~**If yes, how long have you had these thoughts** 0T~~

~~**If yes, specific plan:** 0T~~

~~**Access to means to carry out plan:** 0T~~

~~**Source of Information:** ☐Respondent ☐Affiant ☐Chart Review ☐Other~~

~~Violence Risk Factors Present~~

~~**Present**~~	~~**Unknown**~~		~~**Present**~~	~~**Unknown**~~	
☐	☐	~~Male Gender~~	☐	☐	~~Substance Abuse~~
☐	☐	~~Suspiciousness/Perception of hidden threat~~	☐	☐	~~Comorbid MI & Substance Use Dx~~
☐	☐	~~Early offense history~~	☐	☐	~~Anger~~
☐	☐	~~Psychopathy (PCL:SV>12)~~	☐	☐	~~Antisocial Personality Diagnosis~~
☐	☐	~~Violent Fantasies~~	~~Frequency, type, recency 0T~~		
☐	☐	~~Previous violence against other people~~	~~Frequency, severity, type 0T~~		
☐	☐	~~Childhood physical abuse~~	~~Frequency, severity 0T~~		

~~**Source of Information:** ☐Respondent ☐Affiant ☐Chart Review ☐Other~~

~~Substance Use~~

~~**Do you currently use?**~~

	~~Past Use~~	~~Amount~~	~~Frequency~~	~~Age of Initiation~~

Caffeine	0T	0T	0T	0T
Nicotine	0T	0T	0T	0T
Alcohol	0T	0T	0T	0T
Marijuana	0T	0T	0T	0T
Opioids	0T	0T	0T	0T
Amphetamines	0T	0T	0T	0T
Hallucinogenic	0T	0T	0T	0T
Prescription Medication	0T	0T	0T	0T
Over the counter medication	0T	0T	0T	0T
History of legal charges related to substance use? ☐ Yes ☐ No			Describe: 0T	
				Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other

Physical Appearance

	Attire	Hair	Nails	Skin	
☐ Glasses	☐ Appropriate for occasion	☐ Clean	☐ Clean	☐ Clean	☐ Bruised
☐ Contacts	☐ Appropriate for weather	☐ Dirty	☐ Dirty	☐ Dirty	☐ Cuts/Scrapes
☐ Hearing Aids	☐ Clean	☐ Disheveled	☐	☐ Tattoos Describe: 0T	
	☐ Dirty	☐ Styled			
	☐ Torn/worn through		☐	☐ Sores	
	☐ Other		☐		
Teeth	Unusual alterations or distinguishing features: 0T				
☐ Clean					
☐ Dirty					
☐ Decay					
☐ Missing					
				Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other	

Behavioral Observations

Motor Activity				
Diminished	**Normal**	**Excessive**	**Unusual**	
☐ Frozen	☐ Purposeful	☐ Restless	☐ Other 0T	
☐ Catatonic	☐ Coordinated	☐ Squirming		
☐ Almost motionless	☐ Other 0T	☐ Fidgety		
☐ Little animation		☐ Constant movement		
☐ Psychomotor retardation		☐ Hyperactive		
☐ Slowed reaction time		☐ Other 0T		
☐ Other 0T				
Speech				
Slowed	**Normal**	**Pressured**	**Verbose**	**Unusual**
☐ Minimal response	☐ Initiates	☐ Excessively wordy	☐ Over productive	☐ 0T
☐ Unspontaneous	☐ Alert/responsive	☐ Expansive	☐ Long winded	
☐ Sluggish	☐ Productive	☐ Rapid	☐ Non stop	
☐ Paucity	☐ Animated	☐ Fast	☐ Frequent run ons	
☐ Impoverished	☐ Spontaneous	☐ Rushed	☐ Flight of ideas	
☐ Single word answers	☐ Smooth	☐ Other 0T	☐ Hyper verbal	
☐ Other 0T	☐ Other 0T		☐ Other 0T	
Thought Process				
Attention	**Insight**	**Preoccupations**		
☐ Normal	☐ IGood	☐ Somatics	☐ Self	
☐ Unengaged	☐ Fair	☐ Children	☐ Finances	
☐ Distractible	☐ Poor	☐ Spouse/Sig Other	☐ Other 0T	

~~☐ Hyper vigilant~~	~~☐ No insight~~	~~☐ Job~~		
~~☐ Hyper focused~~				
~~**Source of Information:** ☐Respondent ☐Affiant ☐Chart Review ☐Other~~				
~~**Affect**~~				
~~☐ Flat~~	~~☐ Blunted~~	~~☐ Constricted~~	~~☐ Normal~~	~~☐ Broad~~
~~**Facial Expression**~~				
~~☐ Vacant~~				
~~☐ Blank~~				
~~☐ Strained~~				
~~☐ Pained~~				
~~☐ Grimacing~~				
~~☐ Smiling~~				
~~☐ Other 0T~~				

~~Summary & Recommendations~~

~~Based on the data gathered for the current Pre Evaluation Screening:~~

~~☐ It is **NOT** recommended that this respondent receive a civil commitment exam.~~

~~1) Current available information indicates that present symptomatology is due to~~

~~☐ Dementia ☐Intellectual/Developmental Disability ☐ Epilepsy ☐Chemical Dependency ☐Mental Illness~~

~~2) The following referrals for appropriate evaluation or treatment have been provided:~~

~~a.~~
~~b.~~
~~c.~~

~~☐ It **IS** recommended that this respondent receive a civil commitment exam. Based on the data available for the current Pre Screening Evaluation the following symptomatology cannot be managed/treated in a less restrictive environment:~~

~~1) 0T~~
~~2) 0T~~
~~3) 0T~~
~~4) 0T~~

~~Comments:~~

____
~~Signature Credentials~~

~~Violence Risk Assessment for Certified Holding Facility~~

~~Purpose~~

~~A DMH approved Violence Risk Assessment must be conducted on each individual who is being housed in a DMH Certified Holding Facility. The results of the Violence Risk Assessment will determine if a follow-up assessment by a nurse or physician is needed or if immediate violence prevention protocols must be initiated.~~

~~Timeline~~

~~The Violence Risk Assessment must be conducted immediately upon arrival of an individual at the Holding Facility.~~

~~Signature/Credentials~~

~~The Violence Risk Assessment must be conducted by the designated Screening Officer of the Holding Facility.~~

Violence Risk Assessment for Certified Holding Facility

Detainee's Name ______________________

Date of Birth ______________________

Date ______________________

Name of Facility ______________________

Screening Officer ______________________

FEMALE ☐ MALE ☐ | Most serious charge:

Scoring Instructions: Collect information about each of the 10 risk factor items on the checklist using examples given. Place a check in the box to indicate the degree of likelihood that the risk factor applies to this individual. Use the following indicator scale:

No: Does not apply to this person **Yes:** Definitely applies to a severe degree
Maybe: Applies/present to a moderately severe degree **Do not know:** Too little information to answer

Results: If 5 or more questions are checked YES or MAYBE, notify supervisor and other Holding Facility staff. Initiate proper safety protocols.

1. Previous and/or current violence Physical attack, including with various weapons, towards another individual with intent to inflict severe physical harm. "Yes" means individual has committed at least 3 moderately violent aggressive acts or 1 severe violent act. "Maybe/moderate" means less severe aggressive acts such as kicks, blows and shoving not resulting in severe harm to the victim.	☐ No ☐ Maybe ☐ Yes ☐ Do not know
2. Previous and/or current threats (verbal/physical) Verbal: Statements, yelling, other that involve threat of inflicting physical harm Physical: Movements and gestures that warn of physical attack	☐ No ☐ Maybe ☐ Yes ☐ Do not know
3. Previous and/or current substance abuse History of abusing alcohol, medication and/or other substances including abuse of solvents, glue, similar. "Yes" means extensive abuse/dependence with reduced occupational/educational functioning, reduced health and/or reduced participation in leisure activities.	☐ No ☐ Maybe ☐ Yes ☐ Do not know
4. Previous and/or current major mental illness Individual has or has had a psychotic disorder (schizophrenia, delusional disorder, psychotic affective disorder, other)	☐ No ☐ Maybe ☐ Yes ☐ Do not know
5. Personality Disorder Eccentric (schizoid, paranoid), impulsive, uninhibited (emotionally unstable, antisocial) types	☐ No ☐ Maybe ☐ Yes ☐ Do not know
6. Shows lack of insight into illness and/or behavior Degree to which individual lacks insight into his/her mental illness regarding medication, social consequences of behavior related to illness or personality disorder	☐ No ☐ Maybe ☐ Yes ☐ Do not know
7. Expresses suspicion Expresses verbal or nonverbal suspicion towards others; appears to be "on guard" toward environment/surroundings	☐ No ☐ Maybe ☐ Yes ☐ Do not know
8. Shows lack of empathy Appears emotionally cold, without sensitivity towards others' thoughts or emotional situations	☐ No ☐ Maybe ☐ Yes ☐ Do not know
9. Unrealistic planning Unrealistic plans for future. Unrealistic expectation of support from family and professional/social network. Assess ability to cooperate with/follow plans.	☐ No ☐ Maybe ☐ Yes ☐ Do not know
10. Future stress situations Ability to cope with future stress; ability to tolerate boundaries, physical proximity to possible victims of violence, substance use, homelessness, violent environment, easy access to weapons, other.	☐ No ☐ Maybe ☐ Yes ☐ Do not know

~~Suicide Risk Assessment for Certified Holding Facility~~

~~Purpose~~

~~A DMH approved Suicide Risk Assessment must be conducted on each individual who is being housed in a DMH Certified Holding Facility. The results of the Suicide Risk Assessment will determine if a follow-up assessment by a nurse or physician is needed or if immediate suicide prevention actions must be instituted.~~

~~Timeline~~

~~The Suicide Risk Assessment must be conducted immediately upon arrival of an individual at the Holding Facility.~~

~~Signature/Credentials~~

~~The Suicide Risk Assessment must be conducted by the designated Screening Officer of the Holding Facility.~~

~~Suicide Risk Assessment for Certified Holding Facility~~

~~Detainee's Name~~ ______________________

~~Date of Birth~~ ______________________

~~Date and Time~~ ______________________

~~Name of Facility~~ ______________________

~~Screening Officer~~ ______________________

~~FEMALE~~ ☐ **~~MALE~~** ☐	**~~Most serious charge:~~**

~~Check YES or NO for each numbered item below. Each YES response requires support documentation~~

~~Personal Data Questions~~	**~~YES~~**	**~~NO~~**	**~~Support Documentation~~**
~~1. Individual lacks support of family of friends~~			
~~2. Individual has a history of drug or alcohol abuse~~			
~~3. Individual is very worried about problems other than legal issues (financial, family, medical condition, other)~~			
~~4. Individual has experienced a significant loss within the last 6 months (loss of job or relationship, death of a close family member)~~			
~~5. Individual is expressing feelings of hopelessness~~			
~~6. Individual is thinking about killing himself/herself~~			
~~7. Individual has previous suicide attempt(s)~~			
~~8. Attempt occurred within last month~~			
~~Total number of YES checks~~			

~~Officer's/Staff's Comments/Impressions:~~

~~Action:~~ ~~If total number of YES checks is 4 or more or if item # 6 is checked or if screener believes it is necessary, notify the supervisor and initiate Constant Watch for the individual.~~

~~Supervisor Notified~~ ☐ ~~Yes~~ ☐ ~~No~~
~~Constant Watch Initiated~~ ☐ ~~Yes~~ ☐ ~~No~~

______________________________ ______________________

~~Signature of Screening Officer~~ ~~Badge Number~~

~~Medical/Mental Health Personnel Actions (to be completed by medical/MH staff):~~

~~Section G~~
~~Alzheimer's and Other Dementia Services~~

~~Life Story Narrative~~

~~Life Story Narrative~~

~~Purpose~~

~~As Alzheimer's disease progresses, individuals lose developmental skills and abilities and appear to "move backward in time." A Life Story gives those around them the ability to assist and be with them as they remember the past and work through the stages of the disease. The Life Story Narrative should include specific details about pertinent events and the lifestyle of the individual. Traumatic events that occurred in the individual's life or family should also be included in the narrative.~~

~~Timeline~~

~~The Life Story Narrative must be completed as part of the initial assessment process and must be included in the individual's record. Program staff must review the individual's narrative prior to initial contact with the individual. The Life Story Narrative must also be reviewed whenever the Individual Service Plan is reviewed.~~

~~Narrative Completion~~

~~The Program Supervisor is responsible for completing the narrative and should ask the family and/or responsible party for assistance in completing the narrative. All those individuals who participate in developing the Life Story Narrative must sign where indicated.~~

~~List any significant traumatic events in the "Other" section of the narrative that coincides with the time of life that the trauma occurred. For example, if the individual had a sibling to die in early childhood, list that in the "Other" section of the "Childhood" narrative. If the individual had a stillborn baby or suffered miscarriages, include that information in the "Other" section of the "Young Adulthood" narrative.~~

Life Story Narrative

Name ______________________________

ID Number ______________________________

Date ______________________________

Page 1 of 6

Childhood (Birth - 12 years)

Birth date and birth place: ______________________________

Parents and grandparents: ______________________________

Brothers and Sisters: ______________________________

Birth Order: ______________________________

Friends: ______________________________

Significant relatives: ______________________________

House (s) lived in: ______________________________

Towns lived in: ______________________________

Church (s) attended and activities: ______________________________

Schools attended: ______________________________

Early education events: ______________________________

Interest/activities/sports/games/ etc: ______________________________

Pets: ______________________________

Other: ______________________________

~~Life Story Narrative~~	~~Name~~ ___ ~~ID Number~~ ___ ~~Date~~ ___ ~~Page 2 of 6~~

~~Adolescence (13-21 years)~~

~~Name and location of school (s):~~ ___

~~Favorite/least favorite classes:~~ ___

~~Friends/relationships:~~ ___

~~Interests/hobbies/activities/sports/etc:~~ ___

~~Behavior problems:~~ ___

~~First Job:~~ ___

~~Church (s) attended and activities:~~ ___

~~School(s) attended:~~ ___

~~House(s) lived in:~~ ___

~~Town (s) lived in:~~ ___

~~Pets:~~ ___

~~Specific happy/sad events:~~ ___

~~Other:~~

~~Life Story Narrative~~

~~Name~~ ______________________

~~ID Number~~ ______________________

~~Date~~ ______________________

~~Young Adulthood (21-39 years)~~

~~College and work:~~ ______________________

~~Military Service:~~ ______________________

~~Marriage(s)/Relationship(s):~~ ______________________

~~Family:~~ ______________________

~~Clubs/community involvement:~~ ______________________

~~Church (s) attended and activities:~~ ______________________

~~First home:~~ ______________________

~~Other Homes:~~ ______________________

~~Interests/hobbies/sports:~~ ______________________

~~Town(s) lived in:~~ ______________________

~~Pets:~~ ______________________

~~Specific happy/sad events:~~ ______________________

~~Other:~~ ______________________

Life Story Narrative

Name ______________________

ID Number ______________________

Date ______________________

Page 4 of 6

Middle Age (40-65 years)

Work Role: ______________________

Family Role: ______________________

Marriage(s)/Relationship(s): ______________________

Family: ______________________

Grandchildren: ______________________

Clubs/community involvement: ______________________

Church (s) attended and activities: ______________________

Homes lived in: ______________________

Interests/hobbies/sports: ______________________

Town(s) lived in: ______________________

Pets: ______________________

Specific happy/sad events: ______________________

Other: ______________________

~~**Life Story Narrative**~~	~~**Name**~~ ____ ~~**ID Number**~~ ____ ~~**Date**~~ ____ ~~**Page 5 of 6**~~

~~Later Years (66+ years)~~

~~Work Role:~~ ____

~~Family Role:~~ ____

~~Marriage(s)/Relationship(s):~~ ____

~~Family:~~ ____

~~Grandchildren:~~ ____

~~Clubs/community involvement:~~ ____

~~Life achievements and accomplishments:~~ ____

~~Church (s) attended and activities:~~ ____

~~Homes lived in:~~ ____

~~Interests/hobbies/sports:~~ ____

~~Town(s) lived in:~~ ____

~~Pets:~~ ____

~~Specific happy/sad events:~~ ____

~~Other:~~ ____

~~Life Story Narrative~~

~~Name~~ ____________________

~~ID Number~~ ____________________

~~Date~~ ____________________

~~Page~~ ~~6~~ ~~of~~ ~~6~~

~~Questions to Enrich the Story~~

~~1. How would the individual have enjoyed spending holidays? (New Year's Eve, Christmas, Fourth of July, Memorial Day, etc.)?~~

~~2. What are their favorite books/music/artists/athletes/movies stars, etc?~~

~~3. If the individual was stuck on a desert island, what three (3) things would they wish to have with them? (Assume there is food, drink, and shelter.)~~

~~4. How would the person's desk, kitchen shelves/drawers, tool box, etc., be organized?~~

~~5. Would he/she have looked at life thinking the glass is half-full (optimist) or half-empty (pessimist)?~~

~~6. Where did he/she travel?~~

~~7. What special skills did he/she have?~~

~~8. What special awards did he/she acquire?~~

~~Other~~

~~Section H~~
~~Children and Youth Services~~

~~Therapeutic Foster Care Contact Log~~

~~MAP Team Report~~

~~MAP Team Case Summary~~

~~Wraparound Facilitation Individual Support Plan~~

~~Therapeutic Foster Care Contact Log~~

~~Purpose~~

~~The Therapeutic Foster Care (TFC) Specialist must document face-to-face contact with TFC parents including home visits. Documentation must be maintained that each TFC home has no more than one child/youth with serious emotional disturbance (SED) placed in the home at one time.~~

~~Timeline~~

~~Documentation of at least one family session per month with the foster parent(s) must be maintained.~~

~~Therapeutic Foster Care Contact Log~~	**~~Foster Parent's Name~~** ______________________ ______________________ **~~Foster Parent's Case Number~~** ______________________

~~Date~~	~~Type of Contact (in-home, monthly group, meeting, other)~~	~~Total # of children/youth in the home~~	~~Total # of children/youth with SED in the home~~	~~Staff Signature/ Credential~~

~~MAP Team Report~~

~~Purpose~~

~~Making a Plan (MAP) Teams address the needs of children/youth with Serious Emotional Disorder (SED) who require services from multiple agencies and multiple program systems and who can be diverted from inappropriate institutional placement. MAP Teams are a significant piece of the statewide System of Care for children/youth with serious emotional/behavioral disorders. Quarterly reports are required for data collection purposes.~~

~~Timelines~~

~~The MAP Team Reporting form must be completed and submitted to the DMH, Division of Children & Youth Services by the 10th of each quarter; January 10th for October – December, April 10th for January – March, July 10th for April – June, and October 10th for July – September.~~

~~Case Summaries~~

~~If MAP Team grant funds are used, Case Summary forms for each child/youth reviewed must be submitted with the MAP Team Report. Cash requests will not be processed without this information.~~

~~MAP Team Report~~	**~~MAP Team~~** ______________________ **~~Months/Quarter~~**

~~Referral Information~~

~~1. Number of **new cases** reviewed~~	
~~2. Number of children/youth in DHS custody (of the new cases only)~~	
~~3. Number of follow-ups from previous quarter~~	
~~4. Number of children/youth not Medicaid eligible~~	

~~5. Number of referrals from **new cases** only:~~

	~~Mental Health Center in your county~~		~~Mental Health Center Region-Wide~~
	~~Child Protective Services~~		~~Youth Court~~
	~~Therapeutic Group Home~~		~~Therapeutic Foster Care~~
	~~Acute Psychiatric Hospital~~		~~Psychiatric Residential Tx Facility~~
	~~Local School District~~		~~Parent(s)~~
	~~Faith-Based Agency/Church~~		~~A.O.P~~
	~~MYPAC~~		~~College/University~~
	~~Substance Abuse Residential Facility~~		~~Other (specify)~~

~~MAP Team Member Participation~~

~~Check the following agencies that were represented at your MAP Team Meeting(s) for the quarter~~

	~~Families/Parents (Local Family Partners – must be parent(s) or primary caregiver(s) of a child/youth with SED. Use Families As Allies Partners when available.)~~		
	~~Community Mental Health Center~~		~~Child Protective Services~~
	~~Youth Court~~		~~Local School District~~
	~~Vocational Rehabilitation~~		~~Health Department~~
	~~Boys & Girls Club~~		~~Law Enforcement~~
	~~Substance Abuse Residential Facility~~		~~A. O. P.~~
	~~Youth Villages~~		~~MYPAC~~
	~~Faith-based Agency/Church~~		~~Other (specify)~~

~~MAP Team Case Summary~~

~~Purpose~~

~~Making a Plan (MAP) Teams address the needs of children/youth with Serious Emotional Disturbance (SED) who require services from multiple agencies and multiple program systems and who can be diverted from inappropriate institutional placement. All Community Mental Health Centers must document participation in at least two MAP Teams in their region.~~

~~Timeline~~

~~If DMH flexible funds are utilized, a MAP Team Case Summary form must be completed for each child/youth and submitted to the DMH, Division of Children & Youth Services by the 10th of each quarter; January 10th for October – December, April 10th for January – March, July 10th for April – June and October 10th for July – September along with the MAP Team Monthly Reporting form.~~

~~Identifying Information~~

~~To ensure confidentiality, the child/youth's ID number (CMHC or other provider) is entered on the MAP Team Case Summary in place of the child/youth's name.~~

~~Referral Information~~

~~All questions in all sections must be answered with as much detail as possible in order to justify the need for MAP Team intervention. Space is provided for the specific recommendations of the MAP Team after all aspects of the case have been considered by the team.~~

~~MAP Team Case Summary~~	**~~MAP Team Name~~**	
	~~ID Number~~	
	~~SED Dx~~	
	~~ID/DD Dx~~	

~~Age~~		**~~Race~~**		**~~Sex~~**	
~~Transitional Needs?~~ ☐ ~~Yes~~ ☐ ~~No~~					

~~Why was this child/youth's case referred to the MAP Team?~~	
~~Why is this child/youth considered to be at-risk for an institutional mental health placement?~~	
~~Recommendations of the MAP Team~~	
~~If MAP Team flexible funds will be used for this child/youth, indicate the estimated amount agreed upon by the Team.~~	
~~If MAP Team flexible funds will be used for this child/youth,~~ *~~how will the use of these funds keep the child/youth in the community in a manner that makes it possible for the child/youth to be diverted from an inappropriate 24-hour institutional mental health placement~~*~~?~~	

~~Signature of MAP Team Coordinator/Credentials~~ ~~Date~~

~~Wraparound Facilitation~~

~~Overview of Wraparound~~

~~**Wraparound** is an approach to individualized care planning encompassing the concept of wrapping services and supports around children, youth and families, utilizing both clinical treatment services and natural supports. Wraparound is built on the collective action of a committed group of family, friends, community, professionals, and cross-system supports mobilizing resources and talents from a variety of sources. This results in the creation of an Individualized Support Plan that is the best fit between the family vision and story, strengths, needs, team mission, and strategies.~~

~~Target Population~~

~~Wraparound facilitation is for children/youth with serious emotional disturbances (SED) who have highly complex needs and/or have multiple agency involvement and are at risk of out-of-home placement. With ratios of 1 Wraparound Facilitator to 10 families and youth, youth can be diverted from residential placements and served in their communities and homes.~~

~~Key Elements of the Wraparound Process~~

~~Grounded in a Strengths Perspective~~

~~Strengths are defined as interests, talents, and unique contributions that make things better for the family and youth. Within an entire process that is grounded in a strengths perspective, the family story is framed in a balanced way that incorporates family strengths rather than a focus solely on problems and challenges. A strengths perspective should be overt and easily recognized, promoting strengths that focus on the family, team, and community, while empowering and challenging the team to use strengths in a meaningful way.~~

~~Driven by Underlying Needs~~

~~Needs typically define the underlying reasons why behaviors happen in a situation. In a needs-driven process, the set of underlying conditions (needs) that cause a behavior and/or situation to exist are both identified and explored in order to understand why a behavior and/or situation happened. These needs would be identified across family members in a range of life areas beyond the areas defined by the system. These underlying conditions would be articulated with overt agreement with the family and all team members about which to select for action or attention first. The process involves flexibility of services and supports that will be tailored to meet the needs of the family and youth.~~

~~Supported by an Effective Team Process~~

~~Wraparound is a process that requires active investment by a team, comprised of both formal and informal supports willing to be accountable for the results. Measurable target outcomes are derived from multiple team member perspectives. The team's overall success is demonstrated by how much closer the family is to their vision and how well the family needs have been addressed.~~

~~Determined by Families~~

~~A family-determined process includes both youth and caregivers with the family having the authority to determine decisions and resources. Families are supported to live a life in a community rather than in a program. The critical process elements of this area include access, inclusion, voice, and~~

~~ownership. Family access is defined as inclusion of people and processes in which decisions are made. Inclusion in decision making implies that families should have influence, choice and authority over services and supports identified in the planning process. This means that they should be able to gain more of what is working and less of what they perceive as not working. Family voice is defined as feeling heard and listened to, and team recognition that the families are important stakeholders in the planning process. Therefore, families are critical partners in setting the team agenda and making decisions. Families have ownership of the planning process in partnership with the team when they can make a commitment to any plans concerning them. In Wraparound, the important role of families is confirmed throughout the duration of care.~~

~~Wraparound Facilitation~~

~~Wraparound Facilitation is the creation and facilitation of a child and family team for the purpose of developing a single plan of care to address the needs of youth with complex mental health challenges and their families. The child and family team will meet regularly to monitor and adjust the plan of care if necessary or if progress is not being made. Wraparound facilitation is intended to serve individuals with serious mental health challenges that exceed the resources of a single agency or service provider, experience multiple acute hospitals stays, are at risk of out-of-home placement or have been recommended for residential care. Individuals who have had interruptions in the delivery of services across a variety of agencies due to frequent moves, failure to show improvement, lack of previous coordination by agencies providing care, or reasons unknown can also be served through wraparound facilitation.~~

~~Wraparound facilitation must be provided in accordance with high fidelity (as outlined below) and quality wraparound practice.~~

1. ~~Services comprised of a variety of specific tasks and activities designed to carry out the wraparound process, including:~~

    a. ~~Engaging the family;~~
    b. ~~Assembling the child and family team;~~
    c. ~~Facilitating a child and family team meeting at a minimum every thirty (30) days;~~
    d. ~~Facilitating the creation of a plan of care, which includes a plan for anticipating, preventing and managing crisis, within the child and family team meeting;~~
    e. ~~Working with the team in identifying providers of services and other community resources to meet family and youth needs;~~
    f. ~~Making necessary referrals for youth;~~
    g. ~~Documenting and maintaining all information regarding the plan of care, including revisions and child and family team meetings;~~
    h. ~~Presenting plan of care for approval by the family and team;~~
    i. ~~Providing copies of the plan of care to the entire team including the youth and family/guardian;~~
    j. ~~Monitoring the implementation of the plan of care and revising if necessary to achieve outcomes;~~
    k. ~~Maintaining communication between all child and family team members;~~
    l. ~~Monitoring the progress toward needs met and whether or not the referral behaviors are decreasing;~~
    m. ~~Leading the team to discuss and ensure the supports and services the youth and family are receiving continue to meet the caregiver and youth's needs;~~

n. ~~Educating new team members about the wraparound process; and~~
o. ~~Maintaining team cohesiveness.~~

2. ~~Child and family team membership must include:~~

   a. ~~The wraparound facilitator;~~
   b. ~~The child's service providers, any involved child serving agency representatives and other formal supports, as appropriate;~~
   c. ~~The caregiver/guardian;~~
   d. ~~Other family or community members serving as informal supports, as appropriate; and~~
   e. ~~Identified youth, if age nine (9) or above, unless there are clear clinical indications this would be detrimental. Such reasons must be documented clearly throughout the record.~~

3. ~~Wraparound facilitation is limited to one hundred (100) units (15 minute unit) per state fiscal year and eight (8) units per day.~~

4. ~~Provider requirements~~

   a. ~~Wraparound facilitators and supervisors of the process must have completed and show evidence of completion of the Introduction to Wraparound 3-day training.~~
   b. ~~Wraparound facilitators and supervisors must participate in ongoing coaching and training as defined by the Division of Medicaid and the Department of Mental Health.~~
   c. ~~The provider organization providing Wraparound facilitation must be participating in the wraparound certification process through the Division of Medicaid or its designee.~~
   d. ~~Providers must ensure case load size for each wraparound facilitator of no more than ten (10) cases.~~

~~Wraparound Facilitation Additional Documentation Requirements~~

~~All contacts, specific tasks and activities must be documented in Progress Note and filed in the child/youth's record.~~

~~Wraparound Facilitation~~
~~Individualized Support Plan~~

~~Youth Name (First, MI, Last):~~		**~~Client #:~~**	**~~TAN #:~~**	**~~Date:~~**
~~Guardian Name:~~	**~~DOB:~~**	**~~Phone:~~**	**~~Address:~~**	
☐ ~~Initial~~ ☐ ~~Review~~ ☐ ~~Discharge~~		**~~Start Date:~~**	**~~Target Completion Date:~~**	
~~Vision/Mission/Strengths~~				
~~Family Vision/Preference Statement:~~				
~~Team Mission:~~				
~~Strengths/Abilities: Youth, Family Members, & Team~~				

~~**Client Name**~~	~~**Case #**~~
~~**Crisis Plan**~~	
~~**Diagnosis:**~~	
~~**Medications:**~~	
~~**Brief History:**~~	
~~**Triggers:**~~	
~~**Potential Crisis:**~~	
~~**Action Steps for home and school to meet Identified Needs re: Potential Crisis:**~~	
~~**Persons Responsible and phone numbers:**~~	
~~**Crisis Debriefing after Resolution:**~~	

~~Client Name~~		**~~Case #~~**

~~Needs Statements/Strategies~~

~~Needs Statement 1~~		~~Start Date:~~ ~~End Date/Duration:~~
~~Outcome:~~		

~~Life Domain Area of need~~:

☐ ~~Family~~ ☐ ~~Residence~~ ☐ ~~Social~~ ☐ ~~Education/Vocation~~

☐ ~~Medical/Physical Health~~ ☐ ~~Community~~ ☐ ~~Psychological/Emotional/Behavioral~~

☐ ~~Safety~~ ☐ ~~Basic Physical Needs~~ ☐ ~~Financial~~ ☐ ~~Leisure/Recreation~~

~~Youth Strategies~~	

~~Parent/Guardian/Community Strategies:~~

~~Strategy Completion Date:~~	**~~Strategy Discontinue Date:~~**	**~~Reason for Discontinuation:~~**

~~**Client Name**~~		~~**Client #**~~
~~**Needs Statement 2**~~		~~Start Date:~~ ~~End Date/Duration:~~
~~**Outcome:**~~		

~~**Life Domain Area of need**~~:

☐ ~~Family~~ ☐ ~~Residence~~ ☐ ~~Social~~ ☐ ~~Education/Vocation~~

☐ ~~Medical/Physical Health~~ ☐ ~~Community~~ ☐ ~~Psychological/Emotional/Behavioral~~

☐ ~~Safety~~ ☐ ~~Basic Physical Needs~~ ☐ ~~Financial~~ ☐ ~~Leisure/Recreation~~

~~**Youth Strategies**~~	

~~**Parent/Guardian/Community Strategies:**~~

~~**Strategy Completion Date:**~~	~~**Strategy Discontinue Date:**~~	~~**Reason for Discontinuation:**~~

~~**Client Name**~~		~~**Client #**~~
~~**Needs Statement 3**~~		~~**Start Date:**~~ ~~**End Date/Duration:**~~
~~**Outcome:**~~		
~~**Life Domain Area of need**~~:		
☐ ~~Family~~ ☐ ~~Residence~~ ☐ ~~Social~~ ☐ ~~Education/Vocation~~ ☐ ~~Medical/Physical Health~~ ☐ ~~Community~~ ☐ ~~Psychological/Emotional/Behavioral~~ ☐ ~~Safety~~ ☐ ~~Basic Physical Needs~~ ☐ ~~Financial~~ ☐ ~~Leisure/Recreation~~		
~~**Youth Strategies**~~		
~~**Parent/Guardian/Community Strategies:**~~		
~~**Strategy Completion Date:**~~	~~**Strategy Discontinue Date:**~~	~~**Reason for Discontinuation:**~~

~~Client Name~~			~~Client #~~
~~Needs Statement 4~~			~~Start Date:~~ ~~End Date/Duration:~~
~~Outcome:~~			

~~Life Domain Area of need~~:

☐ ~~Family~~ ☐ ~~Residence~~ ☐ ~~Social~~ ☐ ~~Education/Vocation~~

☐ ~~Medical/Physical Health~~ ☐ ~~Community~~ ☐ ~~Psychological/Emotional/Behavioral~~

☐ ~~Safety~~ ☐ ~~Basic Physical Needs~~ ☐ ~~Financial~~ ☐ ~~Leisure/Recreation~~

~~Youth Strategies~~	

~~Parent/Guardian/Community Strategies:~~

~~Strategy Completion Date:~~	~~Strategy Discontinue Date:~~	~~Reason for Discontinuation:~~

~~**Client Name**~~		~~**Client #**~~
~~**Team Contacts/Resources**~~		
~~**Support Name/Signature**~~	~~**Contact and Organization**~~	~~**Role**~~

~~Discharge~~

~~**Support Summary:**~~

~~**Further Recommendations:**~~

~~Youth Signature:~~	~~Date:~~
~~Parent/Guardian Signature:~~	~~Date:~~
~~Wraparound Facilitator Signature:~~	~~Date:~~
~~Supervisor Signature:~~	~~Date:~~
~~Other Signature (Name/Relationship):~~	~~Date:~~
~~Other Signature (Name/Relationship):~~	~~Date:~~

Case # ~~__________________~~

~~Wraparound Team Meeting~~

~~Wraparound team for ____________________________and Family~~

~~Date:________________________ Start End Time: ____________________~~

~~* I am aware that everything said in this meeting is confidential. Confidentiality means that what we discuss is private and should not be discussed outside of this meeting or with others not involved in this family's Wraparound process. By signing, I agree to preserve the confidentiality of all information discussed. I agree that this information will be used for the purposes outlined in the Wraparound planning process only. I understand that if any abuse or neglect is disclosed in this process, mandated reports will be made.~~

~~**Name of Family Team Member***~~	~~**Role, Agency, or Relationship to Youth**~~	~~**Phone Number(s)**~~	~~***To be filled out by Wrap Facilitator*: Release authorized?**~~
	~~Wrap Facilitator~~		
			~~Y or N~~
			~~Y or N~~
			~~Y or N~~
			~~Y or N~~
			~~Y or N~~
			~~Y or N~~
			~~Y or N~~
			~~Y or N~~
			~~Y or N~~

~~"*Wraparound* is a family centered, community-oriented, strengths-based, highly individualized planning process aimed at helping people achieve important outcomes by helping them meet their unmet needs both within and outside of formal human services systems, while they remain in their neighborhoods and homes, whenever possible" (wraparoundsolutions.com).~~

~~Section I~~
~~Intellectual/ Developmental Disabilities Services~~

~~IDD Plan of Services and Supports~~

~~IDD Activity Support Plan~~

~~IDD Service Note~~

~~IDD Weekly Service Note~~

~~ID/DD Waiver/IDD CSP Service Authorization~~

~~ID/DD Waiver Home and Community Supports Service Agreement~~

~~ID/DD Waiver In-Home Respite Service Agreement~~

~~ID/DD Waiver In-Home Nursing Service Agreement~~

~~ID/DD Waiver In-Home Nursing Respite Service Note~~

~~IDD Employment Profile~~

~~ID/DD Waiver Job Discovery Profile~~

~~IDD Request for Behavior Support and/or Crisis Support Services~~

~~ID/DD Waiver Medical Verification for Behavior Support/Crisis Intervention Services~~

~~ID/DD Waiver Functional Behavior Assessment~~

~~ID/DD Waiver Behavior Support Plan~~

~~ID/DD Waiver Justification for Behavior Support Services~~

~~ID/DD Waiver Behavior Support Quarterly Review Report~~

~~ID/DD Waiver Request for Additional Behavior Support Services~~

~~ID/DD Waiver Request for Additional Crisis Support Services~~

~~ID/DD Waiver Request for Crisis Intervention Services~~

~~ID/DD Waiver Crisis Intervention Plan~~

~~ID/DD Waiver Crisis Intervention Daily Service Note~~

~~ID/DD Waiver Crisis Intervention Log- Episodic~~

~~ID/DD Waiver Request for Additional Crisis Intervention Services~~

~~Plan of Services and Supports~~

~~General~~

~~The Plan of Services and Supports is to be used by Support Coordinators, Targeted Case Managers, Transition Coordinators and providers of non-Waiver/IDD Community Support Program (CSP) services.~~

~~If a person receives non-Waiver Supervised Living and Work Activity Services and/or Supported Employment Services, the Supervised Living provider is responsible for arranging the PSS meeting and having all providers present. If a person receives only Work Activity or non-Waiver/IDD CSP Supported Employment services, that provider is responsible for arranging for the PSS meeting.~~

~~Timelines~~

~~Support Coordinators: The PSS must be revised and submitted to BIDD within 45 days of a person's recertification date.~~

~~Targeted Case Managers: The PSS must be revised and submitted to BIDD within 45 days of a person's recertification date.~~

~~Non-Waiver/IDD CSP Providers: The PSS is to be completed annually or within 30 days of admission to a service. It is to be kept in the file for BIDD review. The Activity Support Plan is to be developed within 30 days of the date the PSS was developed.~~

~~PLAN OF SERVICES AND SUPPORTS INSTRUCTIONS~~

~~Plan of Services and Supports Overview~~

~~The Plan of Services and Supports (PSS) document reflects a person's vision of their desired life. It includes a description of the person's strengths, what is important to and for them, and supports necessary to live their best life. The PSS contains the outcomes that lead to the development of a person's supports and services. The outcomes indicate what a person wants their life to look like. The PSS is developed by the person with the involvement of others identified by the person, such as family, friends, and service providers, and is facilitated by the person's ID/DD Waiver Support Coordinator (SC), IDD Community Support Program Targeted Case Manager (TCM), or a Regional Program's Transition Coordinator (TC). The planning team uses the PSS as a guide to developing needed paid supports and services as well as natural and unpaid supports from the community. It is the fundamental document used to assist the person in achieving their desired outcomes and thus their best life. The PSS meeting and the 4th Quarterly meeting can be combined.~~

~~Plan of Services and Supports Format~~
~~The PSS document is divided into six (6) parts:~~

- ~~I. Essential Information~~
- ~~II. Personal Profile~~
- ~~III. Person Centeredness~~
- ~~IV. Signatures~~
- ~~V. Shared Planning~~
- ~~VI. Activity Support Plans~~

~~**Part I**~~
~~**Essential Information (EI)**~~
~~This part is completed prior to the Plan of Services and Supports meeting. For the person's first PSS, the Essential Information should be gathered during a conversation with the person/legal representative/family member either via phone or in person. The SC/TCM will keep the Essential Information current throughout the year. Address each section for which information is available, regardless of whether or not it is a required section to be completed through the LTSS system. For example, the Employment Section is not required for submission of the PSS to BIDD. However, it must be completed if the person is eighteen (18) years old or above.~~

~~**Parts II – IV**~~
~~**Personal Profile, Person-Centeredness, and Signatures**~~
~~These parts contain information that will be gathered during the PSS meeting. Each member of the person's planning team must contribute information that will best help others learn about the person and how to support them.~~

~~**Part V**~~
~~**Shared Planning – Outcomes**~~
~~Ideas for outcomes must be developed during the PSS meeting.~~

~~**Part VI**~~
~~**Activity Support Plans (ASP)**~~
~~Activity Support Plans are developed by providers, based on the outcomes developed in Part V-Shared Planning, after they receive the BIDD approved PSS from the SC/TCM.~~

~~**Information Gathering**~~
~~The Plan of Services and Supports should paint a picture of the focus person's life. The person is the expert on his/her life and should contribute as much information as possible. Other team members should consist of the supports in the person's life that are closest and know him/her the best. All providers that work closely with the person are required to contribute to the PSS. The PSS should help the team understand the person, what the person wants and needs, and how best to support him/her to live the life he/she desires.~~

~~With the focus person's permission, information is also obtained from others with whom the person interacts. These supports may not be able to attend the PSS meeting but can contribute information prior to the meeting via the SC/TCM/TC. This information is gathered over the phone and documented in planning notes along with the date the conversation took place. The SC/TCM/TC is responsible for sharing this information at the planning meeting.~~

~~Person Centered Thinking Skills© (PCT) developed by *The Learning Community* will be used during the planning meeting to gather information. The Person Centered Thinking skills provide a structure for gathering information during a conversation rather than simply having a question/answer session. With the SC/TCM/TC acting as the facilitator and the person acting as co-facilitator of the planning meeting, the team must work together to obtain all the information that goes in the PSS.~~

~~**********Always remember to ask "why," especially when people give yes/no answers. "Why" provides an important avenue of exploring topics further. **********~~

~~Person Centered Thinking Skills© (PCT) are used as a way to gather information during the PSS meeting. The skills can also be useful throughout a person's certification year to gather and organize information. The PCT Skills include:~~

- ~~The Relationship Map©~~
- ~~Important To and For©~~
- ~~Working and Not working©~~
- ~~4+1 Questions©~~
- ~~Communication Chart©~~
- ~~Good Day/Bad Day©~~
- ~~Routines and Rituals©~~
- ~~2 Minute Drill©~~
- ~~The Donut©~~
- ~~Matching Profile©~~
- ~~Learning Log©~~

~~***Write the person's name at the top of each Skill or note page. SCs/TCM/TCs must submit their notes/ PCT Skills© forms to BIDD as attachments to the PSS. Providers must maintain theirs in the person's record for BIDD review.***~~

~~The SC/TCM/TC and all providers are responsible for taking notes during the planning meeting. Notes can be written on flip chart paper, the PCT Skills© forms or regular paper depending on what is comfortable for the person and team. SCs/TCMs/TCs are not required to provide copies of their notes/ PCT Skills© forms to providers. Providers must have their own notes/ PCT Skills© forms to be able to develop Activity Support Plans for the outcomes they are responsible for implementing. Notes/ PCT Skills© forms will be used by the BIDD to monitor PSSs and Activity Support Plans.~~

~~Completing the PSS~~

~~The following instructions and examples should be used as a guide to completing a PSS.~~ ~~***The examples do not encompass all items required in each section. These examples must not be used in writing a future PSS.***~~ ~~Instructions are organized in the sequence in which they appear in the PSS document. Once the PSS is approved by BIDD, everyone on the team will receive a complete copy of the plan – including the Essential Information.~~

~~Part I: Essential Information~~

~~This part of the PSS should be completed by the Support Coordinator/Targeted Case Manager/Transition Coordinator prior to the PSS meeting. The information should be obtained through a conversation(s) with the person/legal representative/family either via phone or in person. The Essential Information can also be completed with staff if they are the ones most likely to have any of the current information. Certain items can be completed prior to the planning meeting but must be reviewed with the person's team at the beginning of the meeting. At the beginning of the PSS meeting, the following items must be reviewed:~~

- ~~Medications~~
- ~~Back-up and Emergency Plans~~
- ~~Risk assessment~~
- ~~Employment~~
- ~~Behavior Supports *(If a person has a Behavior Support Plan, it must be reviewed and documented in the notes/ PCT Skills forms and be attached to the PSS.)*~~

- ~~***Contact Information*** - Complete the identification information for the person and his/her family members. The person's address must be entered in the Personal Profile section of LTSS.~~

- ~~In the Family Contact Information, include any family members that will not be listed in the "Natural Supports" section. The Emergency Contact is to be entered in the Personal Profile section of LTSS.~~

- ~~**ID/DD Waiver/IDD Community Support Program Supports**~~
  ~~Depending upon the program, this section includes ID/DD Waiver Supports or IDD Community Support Program Supports as well as those not funded by either program.~~

~~***This section should not be generic definitions of services or include medical/institutional terminology. It must be specific to the person and contain enough information and justification to support the services a person is approved to receive*** – the **why, when and how**. The information listed below must be included in the PSS.~~

~~**ID/DD Waiver Supports**~~	~~**IDD Community Support Program Supports**~~
• ~~List the services/supports provided through the ID/DD Waiver along with all the necessary contact information for each agency *(email address is required)* Use the email address of the staff member who is most likely the appropriate staff to receive alerts from LTSS~~ • ~~Indicate the frequency of the service/support (hours per day, month or year)~~ • ~~Describe in detail: *WHEN* the person uses the service; *HOW* the person utilizes the service; and *WHY* the person needs the service/support.~~ • ~~Include a set schedule if there is one or the times services are usually provided~~ • ~~If the service is Home and Community Supports, indicate if a family member is providing the service, their relationship to the focus person, and how many hours per month they provide~~ • ~~All direct support professionals (DSPs) must be reflected on the Relationship Map~~	• ~~List the services/supports provided through the IDD CSP along with all the necessary contact information for each agency *(email address is required)*~~ • ~~Indicate the frequency of the service/support (hours per day, month or year)~~ • ~~Describe in detail: WHEN the person uses the service; HOW the person utilizes the service; and WHY the person needs the service/support.~~ • ~~Include a set schedule if there is one or the times services are usually provided~~ • ~~All direct support professionals (DSPs) must be reflected on the Relationship Map~~
~~**Non-Waiver Agency Supports**~~	~~**Non-IDD CSP Program Supports**~~
• ~~List the agencies that provide services/supports to the person through avenues other than the ID/DD Waiver along with all the necessary contact information for each agency~~ • ~~Provide a brief summary of how, when and why the support is used~~ • ~~Examples of non-Waiver agency supports are Vocational Rehabilitation, Physical Therapy, Community Support Services, Counseling, etc. All supports listed here must also be reflected on the Relationship Map.~~	• ~~List the agencies that provide services/supports to the person through avenues other than the IDD CSP along with all the necessary contact information for each agency~~ • ~~Provide a brief summary of how, when and why the support is used~~ • ~~Examples of IDD CSP agency supports are Vocational Rehabilitation, Physical Therapy, Counseling, etc. All supports listed here must be reflected on the Relationship Map.~~

- ~~**Natural Supports**~~
  - ✓ ~~List the people who provide unpaid supports to the focus person.~~
  - ✓ ~~Include family, friends, neighbors, people who support the person in the community and anyone else the person wishes to include. This could include those that provide support through a church, job or a volunteer program.~~
  - ✓ ~~Include names (first and last) of the natural support rather than “family” or “friends” since this section will pre-populate the Shared Planning section in LTSS.~~
  - ✓ ~~Indicate the natural support’s relationship to the person, their phone number and how and when they provide support to the person. This must include how often the natural support sees or speaks with the person and what they do together. If the phone number is unavailable, enter 000-000-0000.~~
  - ✓ ~~All natural supports listed here must be reflected on the Relationship Map.~~
  - ✓ ~~People listed in the center section of the Relationship Map should be reflected in the PSS. If they do not support the person regularly or never but the person wants them on the map, document this information somewhere on the Relationship Map page.~~

- ~~**Medical Information**~~
  - ✓ ~~List the physician(s) who provide services/supports to the focus person and their specialty area such as general practitioner, dentist, neurologist, ophthalmologist, etc.~~
  - ✓ ~~Provide the physician’s contact information.~~
  - ✓ ~~All medical agency services/supports listed here must be reflected on the Relationship Map.~~
    - ➢ ~~**Medications**~~
      - ▪ ~~List all of the current medications the person is taking including over-the-counter medicines.~~
      - ▪ ~~For each medication, indicate the dosage and frequency the person is taking, the physician who prescribed the medication and the reason for taking it. (www.rxlist.com is a good resource for understanding medications and their usage**)**~~
      - ▪ ~~If it is an over-the-counter medication, indicate why they need it or the condition for which it is taken.~~
      - ▪ ~~Indicate if the medicine is used as a psychotropic medication~~
  - ✓ ~~List any chronic health or physical conditions the person has. ***Chronic health or physical conditions are ongoing conditions that the person has lived with and will continue to live with for the foreseeable future.*** (Ex: diabetes, cerebral palsy, hypertension, epilepsy, etc.) Also indicate any diagnoses that are not listed in the evaluation section.~~

- ✓ ~~The ***history of health problems/issues or addresses any illnesses the person experienced in the past but that are not affecting their health and welfare presently***. Include any surgeries or procedures the person has undergone that may affect his/her current situation. (Ex: stroke, heart attack, cancer, removal of organs, no seizures experienced in 5 years, etc.) Also indicate any historical diagnoses that are not listed in the evaluation section.~~

- ✓ ~~Current limitations on physical activities are usually supported by a doctor's note. The SC/TCM/TC is to upload the note into the attachments section of the PSS module under "Other." It may be that a person can only lift a certain amount of weight due to a hurt back or are temporarily restricted from certain activities due to medical issues. (This section does not include Cerebral Palsy, wheelchair, walker or crutches, etc.)~~

- ✓ ~~***If the person was ever admitted to a facility*** (Ex: ICF/IID, Nursing Facility, Rehabilitation Facility, Behavioral Health Facility, etc.) indicate when, where and why they were admitted and the circumstances surrounding discharge.~~

- ✓ ~~List the dates of the most recent physical and dental exams.~~

- ✓ ~~List anything the person may be allergic to and indicate how he/she reacts to the allergen.~~

- ~~**Medical and Mental Health Support Needs**~~

  - ✓ ~~If the person has experienced any physical complaints or other medical issues during the past year, provide a summary of the issue(s) and the outcome. This is where the SC/TCM/TC can list anything that may have come about as a result of a physical exam during the past year.~~

  - ✓ ~~List any special medical items necessary for the person to live comfortably. Indicate the equipment or treatment and *when, why and how* it is used and who is responsible. (Examples: Baclofen pump, G-tube, Peg-tube, oxygen, disposable adult briefs, ventilator, blue pads, Epi-pen, etc.) (Example: Mary is allergic to bees. She keeps an Epi-pen with her at all times.)~~

  - ✓ ~~If the person is receiving Mental Health support services, provide a description of the services/support, when and why the support is needed and how it benefits the person.~~

- ~~**Communication and Equipment/Technology**~~

  - ✓ ~~Indicate the person's method of communication. (Do they use words or gestures to speak?)~~

  - ✓ ~~Describe supports needed for communication (what communication devices, sign language, etc.)~~

  - ✓ ~~Describe any adaptive equipment or assistive technology supports the person uses and why. (Examples: wheel chair, lifts, hospital bed, hearing aids, walker, bath chair, adaptive forks or knives)~~

- ✓ ~~Indicate how the equipment is maintained and who is responsible.~~
- ✓ ~~Describe the back-up plan for power outages if medical equipment is used.~~

- ~~**Risk Assessment**~~

~~The Support Coordinator /Targeted Case Manager/Transition Coordinator completes the Risk Assessment Tool with the focus person, his/her family or legal representative, and providers before the meeting. It will be reviewed at the meeting and all pertinent information will be included in the PSS. List the date(s) the Risk Assessment Tool was completed, any identified risks and the strategies for avoiding identified risks (Resolution) for each. If the person has no identified risks, write "none" in this section and on the Risk Assessment Tool and upload it to LTSS.~~

- ~~**Back-Up and Emergency Plans**~~
  - ✓ ~~Indicate what will happen if the provider does not show up – this includes all services that go to the person's home, not just in-home services.~~
  - ✓ ~~Indicate the actions to take if the day program, work or other activity is canceled or closed.~~
  - ✓ ~~Indicate the actions to take when disasters occur – this refers not only to natural disasters but also to emergencies, issues with housing, staff not being available, issues with evacuation, etc.~~
  - ✓ ~~These plans must include the name and phone number of who the person is to call.~~
  - ✓ ~~Plan for future living arrangements – where will a person live in the future or where will they go if something happens to their home or people they live with.~~

- ~~**Family and Current Living Arrangements**~~
  - ✓ ~~Indicate the current living arrangement for the focus person (at home with parents, at home with siblings, in a supervised living setting, in an apartment with/without a roommate, etc.).~~
  - ✓ ~~State with whom the person lives, and the age, occupation and health condition of everyone living in the home. Provide information about the level of support each individual living in the home provides to the person.~~
  - ✓ ~~Include ALL family listed on the Relationship Map and the amount of support they provide to the person (Example: Aunt Mary lives in Chicago and sees Sue twice a year.)~~
  - ✓ ~~If the person resides in a group home, indicate the roommates' first names.~~
  - ✓ ~~If the person resides alone or in a group home, indicate the extent of the support/interaction he/she has with family as well as the information above.~~

- ~~**Education**~~

  - ✓ ~~Indicate the current school, if applicable. List the name of the last school attended (if known). Indicate if he/she received a certificate of completion or a diploma and the date (an estimate of May 31st and the year of graduation is appropriate). If a person is under the age of 21 and not in school, indicate in the notes the reason(s) why.~~

~~**Employment and Volunteer Activities**~~

  - ✓ ~~If the person currently has a job, indicate where he/she is employed, when he/she began, the days and hours he/she works, and provide a summary of the work duties. If the person's schedule varies, the SC/TCM/TC can choose the days and times the person generally works. ** Estimate the begin date if necessary. Indicate such in the notes.~~

  - ✓ ~~If the person was previously employed, indicate where he/she worked as well as the end date and the reason he/she is no longer employed at that location. Estimate dates and days, if not known, and indicate such in the notes.~~

  - ✓ ~~If a person is not employed, indicate why in the "Duties" column. Employment MUST be addressed at all meetings for people ages eighteen (18) and older and be documented in the PCT Skills/Notes.~~

  - ✓ ~~If the person volunteers somewhere in the community, indicate where, the begin date, the days and hours he/she volunteers and what duties are performed while volunteering. List as many places as applicable. If exact begin dates are not known or if the schedule varies, estimate in this section and indicate such in the notes.~~

  - ✓ ~~If the person volunteered in the past, provide the necessary information, if available. Estimate dates and days, if not known, and indicate such in the notes.~~

  - ✓ ~~If the person has never volunteered, please indicate such in the notes.~~

- ~~**Previous and Current Behavior Supports**~~

  ~~This section includes any and all information regarding ***current or past actions*** that providers would need to know to support the person.~~

  - ✓ ~~If the person is currently or has previously received services to assist in correcting inappropriate actions, indicate what the actions are/were, when they occur or occurred and what was done or is being done to eliminate or change the actions, if necessary.~~

  - ✓ ~~***If the person has a Behavior Support Plan in place, indicate there is a plan being implemented and upload a copy of the plan with the PSS.***~~

  - ✓ ~~If the person currently does things out of the ordinary but they do not need a Behavior Support Plan, list those actions and specifics, if known.~~

- ~~**Serious Incidents During the Past Year**~~

  ~~Write a summary of any serious incidents that occurred during the past certification year. Include information regarding the incident(s) that occurred and how the incident(s) was resolved or the outcome(s) of the incident(s). Indicate if the PSS was changed as a result of the incident.~~

- ~~**Evaluation Information**~~

  - ✓ ~~Record the person's current ICAP score and level, the date the assessment was conducted, and who conducted it.~~

  - ✓ ~~Indicate the date of the most recent Psychological Evaluation and who conducted the evaluation.~~

  - ✓ ~~List the diagnoses given as a result of the evaluation.~~

  - ✓ ~~If there are any diagnoses on Axis I or III, ask which, if any, are still relevant and list them in the Chronic Medical Conditions section, History of Health Problems/Issues section, or Medical Needs section, depending on the nature of the diagnosis.~~

- ~~**Essential Information Completed By**~~

  ~~The SC/TCM/TC completes this section by indicating the person/legal representative/family that provided the information, his/her name, and the date completed. The SC/TCM/TC can indicate in the Notes who else may have provided information for completion of the Essential Information. This person should be listed in the section "Contributors Not at Meeting" if they are not at the actual meeting.~~

~~The Planning Meeting~~

~~***The Support Coordinator/Targeted Case Manager /Transition Coordinator is responsible for facilitating the planning meeting.*** Good facilitation is crucial to complete the Personal Profile. The Personal Profile must be reflective of the person and the supports needed to make sure he/she lives the best life possible. The more information that is elicited during the planning meeting, the stronger the plan will be to support the person. This will entail asking questions to draw information out of the person/team rather than asking yes/no questions. In some cases subjects or ideas may need to be challenged or teased out to determine a way to change something or make something new and different happen that is important to or for the focus person. *If optimistic discontent is not created, change will not occur.*~~

- ✓ ~~The key to a good person centered plan is asking "why" when gathering information and understanding the "why" when reviewing the PSS.~~

- ✓ ~~Remember the plan belongs to the person and is about what they want for their life rather than what the family and providers think is best for them. Plan WITH the person rather than FOR the person.~~

- ✓ ~~The plan must always be current and reflect what is happening in the person's life. The person must be aware of the process for requesting changes and updates to their PSS throughout the year and not just at the annual planning meeting in order for the document to always be~~

~~current. Requests for change should be made to the Support Coordinator/Targeted Case Manager. The person/legal representative must make the request. Providers can inform the Support Coordinator/Targeted Case Manager of issues that may be occurring, but the request for additional services must come from the person/legal representative. The process must be explained during the planning meeting so all team members are aware of the process.~~

- ✓ ~~The Personal Profile is written in the present tense rather than describing what has happened in the past or what may happen in the future.~~

- ✓ ~~Using people's first names in a PSS makes the plan more person centered. It is their plan and they know the people supporting them and their relationship to the support person.~~

- ✓ ~~The PSS must be written in plain language so that it is easily understood by the person and everyone else on their team. Medical or institutional terminology must be avoided.~~

- ✓ ~~Pay attention to behaviors as well as words. People often speak louder with actions than with words. Sometimes people tell us what they think we want to hear rather than how they really feel or what they really think. By reading a person's behaviors, these things can be figured out.~~

- ✓ ~~The Person Centered Thinking Skills© provide a guide for gathering information through a regular conversation rather than a question/answer session. People are more likely to contribute information if they feel comfortable and are not being pressured with answering questions. Make sure everyone at the meeting is included in all aspects of the conversation.~~

- ✓ ~~All information included in the Personal Profile section must come directly from the notes or Person Centered Thinking Skills forms written during the meeting; however not all information gathered will always go into the Personal Profile. Some information may not be appropriate to include in the person's PSS.~~
  - ~~Examples: negative things about the person stated at the meeting; discussions at the meeting that may have not been positive or were hot topics; information gathered/offered that may not be important to know or do, etc. However, these things should be reflected in your notes so that you know they were discussed and can follow up on them at a more appropriate time.~~

- ✓ ~~Information should be recorded as it is expressed during the meeting. When the SC/TCM/TC writes the Personal Profile, he/she organizes the information and determines where it belongs in the PSS. If information is expressed in a negative manner, the SC/TCM/TC should use the "Reframing Reputations" Skill© when writing the information in the PSS. Negatives must be re-worded in the PSS to make them factual, yet not stereotypical or clinical. (Example: "Amy is attention seeking." Could be "Amy wants alone time with staff.")~~

- ✓ ~~The SC/TCM/TC is responsible for organizing the information discussed during the planning process and developing the PSS. The PSS should not be a copy of the PCT Skills©/notes taken during the meeting. Information is gathered using the skills but it does not necessarily belong under that section of the PSS. It may be more appropriate in another section of the PSS.~~
  - ~~Example: Bad Day Skill© – a person says "last minute changes" can cause them to have a bad day. If something has an effect on a person and how they act, that is information that could go under the Important TO or Important FOR section of the PSS. Same with Dislikes – if a person dislikes something, why and what happens? Is this something that is Important To or For them?~~

- ✓ ~~Information in the Personal Profile must be in the form of a sentence. (Example: "Spot is important to Mary because he is her constant companion:" not just "Spot.")~~

- ✓ ~~For people who do not use words to speak, write what a support person may think the focus person would say or do. (Example: "Suzy says she thinks Mary would say playing with Spot is working for her.")~~

- ✓ ~~Once a PSS is developed and implemented, the SC/TCM (not the Transition Coordinator) is responsible for keeping the PSS document current and ensuring all team members have the most recent information.~~

- ✓ ~~If/when changes or revisions are made to the PSS during the certification year, all team members must agree and will then receive an updated copy of the PSS from the SC/TCM.~~

- ✓ ~~Throughout the planning process, it is recognized that sometimes difficult choices may have to be made. Teams are encouraged to be creative in overcoming obstacles such as limited funding, isolated geographical locations and limited community resources in order to support the person in meeting their desired outcomes.~~

- ✓ ~~All information included in the PSS must be written in complete sentences and include "WHY" – For example, someone says attending the day program is important to him/her. WHY is it important to him/her? Is it because they see their friends there?~~

~~Part II: Personal Profile~~

~~The Personal Profile is the core of the person's plan and contains the most vital information – an image of the person and the supports needed to make sure he/she lives his/her best life possible.~~ ***~~Good facilitation and participation of all team members is crucial to completing the Personal Profile.~~***

~~A. Introduction: Great Things about ______~~

~~The Introduction is written with positive, person-first language to introduce the focus person. It emphasizes the positive qualities identified by the person and others that know him/her best. Written correctly, the Introduction should capture the person's spirit and provide a clear impression of the person's admirable qualities and present his/her "positive reputation." It should be worded as if you were introducing the person to someone new.~~

- ~~Example: Mary has a dynamic personality. She has a great sense of humor and loves to make people laugh. Mary is very passionate about things that are important to her such as her dog Spot. She is a loyal friend. Mary loves a challenge and will not give up until she has done what she set out to do.~~

~~B. Hopes and Dreams~~

~~This section describes the hopes and dreams of the focus person at this time in their life. The PSS must reflect the true hopes and dreams of the person and not just what the team believes is obtainable. No hope or dream should go unacknowledged or be dismissed just because team members believe it is unattainable. These must be the person's hopes and dreams. Hopes and dreams should not be tied to health or welfare.~~

~~Ask the questions:~~

- ✓ ~~What would he/she like to accomplish?~~
- ✓ ~~Where does he/she want to go?~~
- ✓ ~~What does he/she hope to have one day?~~
- ✓ ~~What would he/she like to learn to do?~~
  - ~~Example: Mary wants to live in an apartment with her best friends, Kimberly and Susan. Mary hopes that one day she will get the~~

~~chance to go to Washington and meet the president.~~

~~C. Important TO and Important FOR~~

~~Recognizing what is important TO and important FOR a person is the fundamental Person Centered Thinking Skill©. When planning with a person, focus on what is important to the person as well as what is important for them (health and safety). The goal is to balance what is important to/for the person so that they can live a good life.~~

~~IMPORTANT TO:~~

~~These are things in life that are special to the person. This section must include things, when present (or if applicable), that are likely to contribute to a good day, or when absent, are likely to contribute to a bad day. The following areas MUST be addressed:~~

- ✓ ~~Relationships~~
- ✓ ~~Things to do and have~~
- ✓ ~~Community Integration (places to go)~~
- ✓ ~~Rhythm and pace of life~~
- ✓ ~~Rituals and Routines~~
- ✓ ~~Status or control over one's life (choices, decisions, options)~~
- ✓ ~~Anything else the person wishes to include~~

~~Tips:~~

- ~~Do not include items the team thinks are or should be important to the person. This is just what the person thinks.~~

- ~~Remember there is a difference between what someone "likes" and what is "important to" the person. "Likes" can be included in the section "Things People Need to Know and Do to Support the Person and Keep Them Healthy and Safe" or "Strengths."~~

~~IMPORTANT FOR:~~

~~These are things that are necessary in a person's life to ensure their health and welfare. The following areas MUST be addressed but not limited to:~~

- ✓ ~~Things pertaining to issues of health (prevention, treatment, diet, exercise, physical health, mental health, etc.)~~
- ✓ ~~Issues of safety~~
- ✓ ~~Support needs~~
- ✓ ~~Medical conditions~~
- ✓ ~~What is necessary to help the person be a valued and contributing member of their community~~

~~Examples:~~

~~Important to Mary~~	***~~Important for Mary~~***
~~It's important to spend time with best friends, Kimberly and Susan, to laugh and have fun.~~	*~~Spending time with Abby, Sam, and her friends is important for Mary so she has good relationships and supports~~*
~~Spot (puppy) is important to Mary because he is her constant companion.~~	*~~It is important for Mary not to be rushed so she doesn't forget things and become upset.~~*
~~It's important to Mary to choose where she and Suzy (HCS provider) eat lunch and shop so she has some say in what she~~	*~~Being with Suzy is important for Mary. With Suzy, she gets to go do things without her parents.~~*

~~***Important to Mary***~~	~~***Important for Mary***~~
~~*does.*~~	
~~*It's important to Mary to not be rushed; she will forget things and become upset.*~~	~~*Taking care of Spot is important for Mary. It gives her a sense of responsibility and she takes it very seriously*~~

~~D. Working/Not Working~~

~~This section provides a snapshot of what is currently working and not working in a person's life from multiple perspectives. Things that may occur in the future or that need to be prevented are not recorded here. All team members must look through the lenses of the focus person and not just their own. Each service must have its own section and the information working and not working must be relevant to that service/support being provided. Topics addressed MUST include but are not limited to:~~

- ✓ ~~*Living arrangement (where and with whom)*~~
- ✓ ~~*Relationships (family, friends, providers, anyone else)*~~
- ✓ ~~*What the person does for fun*~~
- ✓ ~~*Where they like to go and what they like to do in the community*~~
- ✓ ~~*How the person spends his/her days (include school, day program, job, volunteering, retirement activities, etc.)*~~
- ✓ ~~*The amount of control the person has over life choices (Example: churches, activities, clothes, time they go to bed at night, etc.)*~~
- ✓ ~~*Any plans developed to support the person in addition to the PSS, when applicable. (Example: a Behavior Support Plan, doctor ordered diet, any plans written for restrictions/limitations.)*~~

~~Addressing **ALL** of the items indicated above from each team member's perspective allows the team to think through how to support the person rather than jumping straight to the "fix" for the person.~~

~~The "Not Working" section shows different perspectives which leads to questions as to why something is occurring. In these cases, the information may show up here and in the "Questions/Things to Figure Out" section.~~

~~***Examples: The examples listed below do not encompass all items required to be addressed.***~~

- **~~Perspectives:~~**
  - ✓ ~~Person's perspective – list things the person says are working and not working in his or her life as related to ALL areas listed above. If the person cannot use words to speak, the team may all contribute. Indicate who says what they think Mary would say is working/not working from her perspective.~~

~~***Mary's perspective***~~	
~~*Working*~~	~~*Not Working*~~
~~*Mary thinks taking care of Spot is working. She likes playing with him and feeding him.*~~	~~*Not being able to decide what she wants to eat for lunch at the day program is not working for Mary. She doesn't like some of the food they serve.*~~
~~*Spending time doing fun things with Suzy like getting nails done, going to eat Mexican food, and walking at the park is working for Mary.*~~	~~*Having to sit next to Steve at the day program is not working. He gets on her nerves with his loud mouth.*~~
~~*Mary is happy learning to play games on the computer. She thinks this is working*~~	~~*Suzy not being around enough isn't working for Mary. She misses Suzy*~~

~~***Mary's perspective***~~	
~~*Working*~~	~~*Not Working*~~
~~*well.*~~	~~*when she is gone and thinks they don't get to spend enough time together.*~~

✓ ~~Family's perspective - list things family members see as working and not working for the person regarding the topics listed above. Family members must look through the lenses of the person as well as their own. Ideas/subjects should not be listed in a negative fashion, nor should they violate the person's rights.~~

~~***Abby (mom) and Sam's (dad) perspective***~~	
~~*Working*~~	~~*Not Working*~~
~~*Suzy spending time with Mary and taking her places she wants to go is working.*~~	~~*Not having enough HCS hours to do more things with Suzy on the weekends is not working.*~~
~~*It is working that Mary gets to do new activities and experience new things at the day program.*~~	~~*The weight Mary has gained from eating too many sweets is not working. It is not good for her health and wellbeing.*~~
~~*Mary being able to do things for herself like getting ready to go to the day program is working out well.*~~	~~*Mary not having a job in the community so she can be around more people and make money isn't working.*~~

✓ ~~Provider's perspective - list things the provider(s) see as working and not working for the person regarding the support(s) they are providing. Providers must look through the lenses of the person as well as their own. Each service/support should have a separate working/not working perspective. Ideas/subjects should not be listed in a negative fashion, nor should they violate the rights of the person. The provider should say "why" something is not working.~~

~~***XYZ Agency; HCS; Suzy's perspective***~~	
~~*Working*~~	~~*Not Working*~~
~~*It is working that Mary takes good care of Spot. She loves him so much.*~~	~~*Not enough HCS hours to do more things with Mary isn't working.*~~
~~*Mary and I having fun together laughing and singing in the car is working well for her and me.*~~	~~*It's not working that Mary doesn't have more opportunities to make new friends.*~~
~~*The schedule Abby and I have worked out for me to support Mary works well for everyone.*~~	~~*Mary always asking to go get ice cream isn't working. Her mother says she has gained a lot of weight. I don't like telling her no though.*~~

~~***XYZ Agency; DSA; Dan's perspective***~~	
~~*Working*~~	~~*Not Working*~~
~~*Mary learning to use the computer to play games is working well. She is very good on the computer.*~~	~~*Mary wanting to do everything in the kitchen and not allowing others to have a chance isn't really working.*~~
~~*It is working that Mary keeps the day program calendar up to date. She always*~~	~~*It's not working that Mary doesn't want to get off the van when returning from*~~

~~*XYZ Agency; DSA; Dan's perspective*~~	
~~*Working*~~	~~*Not Working*~~
~~*knows what is going on.*~~	~~*community activities.*~~
~~*Mary eating lunch with her best friends Kimberly and Susan works well for her.*~~	~~*Sitting next to Steve during certain activities doesn't seem to be working for Mary. He gets on her nerves.*~~

~~E. Things People Need to Know (and do) to Support the Person and Keep Them Healthy and Safe~~

~~This section includes information/instructions others need to know and do to support the person. The information should not focus on services but rather on a description of the person and supports necessary for them to have a good life. It should be detailed and specific and be written so it is easy to understand and clearly explains how to provide supports. Any information can be recorded in this section including, but not limited to, inappropriate actions, means of communication, routines, likes, dislikes, coping strategies, relationships, fears or concerns and what to do about them, movement and mobility, seizures, medications, feeding rituals or instructions, treatments and interventions, special considerations, etc. Think about it from a provider's perspective and what they would need to know and do to support someone they just met.~~ ***~~A provider should be able to know what to do for or with someone and when, how and WHY~~***~~. This may be the only part of the PSS a DSP reads.~~

~~Examples:~~

- ✓ ~~Actions that are not appropriate or may cause problems:~~
  - ~~Example: John will hit staff or other people in the program when he doesn't get his way.~~
- ✓ ~~Special considerations that relate directly to the person~~
  - ~~Example: Remind Ryan not to get in other people's faces when talking to them.~~
- ✓ ~~Person's fears or concerns~~
  - ~~Example: Sam is afraid of the dark. Always make sure the nightlight is on before turning out his light at bedtime.~~
- ✓ ~~Movement and mobility - include any approaches, supplies or devices that are used to accomplish movement and mobility; movement patterns and/or habits~~
  - ~~Example: Lizzie uses a power wheelchair to get around. The chair needs to be charged every night. When she goes to the mall, Walmart or out to eat, Lizzie takes her manual wheelchair and needs to be pushed.~~
- ✓ ~~Routines - include routines for the morning, bathing, evening, etc.~~
  - ~~Example: Dottie has a bed bath every other morning and a shower the other days. Dottie does not like having her face wet so staff use a special shower chair that reclines to keep the water out of her face.~~

~~F. Strengths~~

~~This section focuses on what the person can do for him/herself or can do with assistance. Indicate the person's abilities to perform specific activities. This should be a description of the person rather than a list of their positive qualities. The description reflects the person's abilities and likes. Use complete sentences.~~

- ~~Example: Mary has the ability to control her emotions. She likes to make her own decisions. Mary manages her money with the assistance of Sam. She will let you know when she doesn't like something or isn't excited about doing something. Mary uses the microwave to cook popcorn when she watches movies. She gets herself ready for the day program in the morning~~

~~and does her nighttime routine on her own. She loves to ride her bike around the neighborhood.~~

~~G. Referrals~~

~~Describe any referrals necessary for the person. Indicate who will make the referral and by when. (Examples: VR, MH, therapy, etc.)~~

~~H. Questions/Things to figure out~~

~~This section is a place to record things the team does not know about the person and/or questions left unanswered at the end of the planning meeting. More times than not, the team will not know all the necessary information or the answers to all questions.~~

- ✓ *~~Where are we missing information?~~*
- ✓ *~~What do we need to know more about?~~*
- ✓ *~~What do we need to figure out to make something happen or how to better support the person?~~*
- ✓ *~~Always include who will be responsible for following through with getting more information regarding the issue or what they will do. Also include the timeline. If a staff person is responsible, then this information will also go in the person's Activity Support Plan for that specific service.~~*
  - ~~Example: Mary wants to swim more often. Where is a place that has a pool that can accommodate a person who uses a wheelchair? – Shelly from DSA will look into this~~

~~Part III - Person-Centeredness~~

~~All services and supports provided must be person centered. People with disabilities have rights that cannot be violated and must be protected. Each person must be given choices regarding the services and supports they need to live a good life. Each of the following must be addressed in the PSS and there must be a statement associated with each answer:~~

- ✓ ~~Information on what services are available must be presented to the person/legal representative/family in an understandable manner in order for them to make an informed decision on which service(s) they wish to utilize. Explain each applicable service and how it is used.~~

- ✓ ~~Information on all certified providers must be presented to the person/legal representative/family in an understandable manner in order for them to make an informed decision on which provider(s) to utilize.~~

- ✓ ~~Information regarding different living environments/arrangements must be presented to the person/legal representative/family in an understandable manner in order to choose the best living environment/arrangement for the person. Some people living at home with families may not know there are other options. People already living in the community need to know there are other places to live if they are not happy where they are.~~

- ✓ ~~If the person chooses to live in a group setting, there must be documentation that they were given a choice of roommates.~~

- ✓ ~~Unless the person is a minor (under the age of 18) or has a legal guardian/representative (with legal documentation), they should be given control over their personal resources.~~
  - ~~Example: access to money, access to health and wellness, emotional support, spirituality, social supports, etc. If a person's family assists them with making choices or budgeting their money, please indicate this information.~~

- ✓ ~~Documentation must be maintained indicating the **_person is given a choice of activities in their day program and home settings._** Examples must be provided of what the person chooses to do.~~
  - ~~Example: arts and crafts, where to go eat, where to go look for a job; where to shop, etc.~~

- ✓ ~~Any limitations or restrictions must be addressed. Limitations and/or restrictions limit a person's movement, daily activities, choices, access, or functions. Placing limitations and/or restrictions on a person often results in the person losing an object or not getting to do something they enjoy. Positive reinforcement is not present when restrictions are in place. If a person has a limit or restriction, there must be a plan in place supporting the necessity of the restriction/limitation and how it is to be used. A copy of the plan must be attached to the PSS. The plan must include the specific circumstances it will be used in, the fading techniques of the plan and the consent of the person/legal representative to implement the plan. If there is a doctor's note supporting a special diet or other health items, a copy of the medical or a doctor's note must be attached to the PSS.~~
  - ~~Examples of limitations/restrictions: visitors not allowed; having items taken away for certain reasons; food choices not allowed; being limited to a special diet; being told when to eat or sleep.~~

~~Part IV – Signatures~~

~~Everyone at the PSS planning meeting must sign the Signature Page to indicate they participated in developing the PSS. **_Each team member's signature indicates a promise being made to the focus person to work on making their life better by supporting their outcomes._** The signature page also serves to hold those team members accountable for implementing their part of the PSS. If someone did not attend the planning meeting but still contributed information via the SC/TCM/TC, their name and relationship to the person must be indicated in the appropriate section along with the date the information was provided to the SC/TCM/TC. The SC/TCM/TC signs the document last indicating they are responsible for monitoring the implementation of the PSS. The signature page must be uploaded into the LTSS system along with the Skills/Notes from the planning meeting in the attachments section of the PSS module.~~

~~The Support Coordinator/Targeted Case Manager sends a copy of the signature page to providers who attended the meeting.~~

~~Part V - Shared Planning~~

~~The Shared Planning section of the Plan of Services and Supports indicates specific outcomes a person wishes to achieve in order to lead the life they desire. **_Outcomes are developed by the person and his/her team based on <u>what is important TO them</u> according to the information collected and written in the Personal Profile section of the PSS._** The person may want to change an aspect of his/her life, learn to do something new, or continue doing something that is currently working in their life.~~

- ✓ ~~Outcomes are not directed by the services/supports a person receives but rather by the life they wish to live. Outcomes direct the services and supports to be provided. Outcomes are not services a person receives or specific details written on how to support them. They are general statements about living life.~~

  - ~~**_Outcomes must be measurable:_**~~
    ✓~~**_Can you see it?_**~~
    ✓~~**_Can you count it?_**~~

- ~~The Support Coordinator/Targeted Case Manager/Transition Coordinator may choose to use the "Person Centered PSS Outcome Worksheet" to record ideas or recommendations for outcomes as agreed upon at the meeting. The form is optional.~~

- ~~***All outcomes must be written using the following formula:***~~
  ~~***Name + action verb + what/where + so that/in order to = expected results***~~

✓ ~~The "Desired Outcomes" is where each outcome idea developed during the meeting is recorded.~~ ~~***The SC/TCM/TC writes the outcomes after the meeting based on the ideas discussed during the meeting.***~~

✓ ~~The "Provider Services" column indicates who is responsible for completing activities related to each outcome. This may include more than one provider and/or service.~~ ~~***Natural supports can also be responsible for supporting outcomes.***~~ ~~If a natural support is going to support an outcome their name will be pre-populated from the Natural Supports section of the PSS in the LTSS system.~~

✓ ~~The "How Often" column indicates how often activities will be completed while working towards the outcome. The timeframe must indicate if the activity will be completed daily, weekly or monthly. If activities are to be completed weekly or monthly, the number of times of participation/support must be included. The start and end dates will be pre-populated by the LTSS system to reflect the dates of the person's current certification year.~~

~~Examples:~~

~~***Outcome***~~	~~***Desired Outcomes***~~	~~***Provider Services***~~	~~***How Often***~~	~~***Start Date***~~	~~***End Date***~~
~~*1*~~	~~*Mary participates in arts and crafts in order to make things to give to her family and friends.*~~	~~*XYZ Agency/HCS, DSA*~~	~~*3 x per week*~~	~~*10/1/15*~~	~~*9/30/16*~~
~~*2*~~	~~*Mary attends church so that she can worship God and see her friends in Sunday School.*~~	~~*XYZ Agency, HCS*~~ ~~*XYZ Agency, DSA*~~ ~~*Abby and Sam*~~	~~*2 x per week*~~	~~*10/1/15*~~	~~*9/30/16*~~
~~*3*~~	~~*Mary feeds and walks Spot in order to ensure he is healthy and well cared for.*~~	~~*XYZ Agency, HCS*~~ ~~*Abby and Sam*~~	~~*Daily*~~	~~*10/1/15*~~	~~*9/30/16*~~
~~*4*~~	~~*Mary eats out, shops, gets her nails done and does other things in order to enjoy herself and be a part of her community.*~~	~~*XYZ Agency, HCS*~~ ~~*XYZ Agency, DSA*~~ ~~*Abby*~~	~~*4 x per week*~~	~~*10/1/15*~~	~~*9/30/16*~~

~~The Plan of Services and Supports should always be a complete, current snapshot of a person's life. Everyone's life changes all the time. The people who receive supports are no different. Health changes, friends come and go, jobs change, life changing events happen. The plan should always be updated to reflect those changes in order to know the person and what is currently happening in his/her life.~~

~~Planning with a person using Person Centered Thinking Skills© and practices allows you to dig deeper, ask more questions, and find out more about a person than ever before. Always ask "WHY"?? Plans and outcomes are truly individualized. People we support will begin communicating with us and letting us help him/her live the life they want. Only when people see change do they believe it.~~

~~Revisions to the Plan of Services and Supports~~

~~The PSS is a fluid document that is meant to be revised throughout the year as a person's situation changes. Revisions can be made to any section of the PSS. Providers can also ask for changes to a PSS regarding the Shared Planning Section. An outcome may be accomplished or a new outcome may need to be added. Additionally, they may have information regarding an item in the Essential Information Section that may need to be updated. The person/legal representative must agree to all changes either in writing, or via a witness hearing the request. Everyone who attended the most recent in-person PSS meeting must get a copy of the revised PSS.~~

~~Due to changing needs, there could be instances when all members of the team must come together during the person's certification year to review/revise the PSS. For example, a person could have a change in medical condition and new services must be requested, the Personal Profile must be updated and the Shared Planning must be revised. Other examples could include someone moving from their family home to Supervised Living. A new PSS meeting would need to be held to involve the new provider and new outcomes may need to be developed. The revised PSS and signature page would be sent to everyone who attended the meeting.~~

~~Recertification Plans of Services and Supports~~

~~For recertification Plans of Services and Supports, the SC/TCM may take a copy of the current PSS to the PSS meeting. It can be used as the basis of the conversation. All elements of the Essential Information should be kept current throughout the year. Before the PSS meeting, the Support Coordinator/TCM can review the elements with the person/legal representative/service providers to ensure they are up-to-date. However, the following elements of the Essential Information must be reviewed at the PSS meeting to ensure they are, indeed, current:~~

~~Medical Information~~
~~Medications~~
~~Back-up and Emergency Plans~~
~~The Risk Assessment~~
~~Employment~~
~~Behavior Supports (if applicable)~~
~~Any restrictions~~

~~The Skills to be used at each meeting will vary from person to person. The SC/TCM must use their judgement to determine which Skills may be necessary to gather additional information. Any new Skills and all notes taken at the PSS meeting must be submitted to BIDD with the recertification PSS. The Relationship Map is the only required Skill to be used. It is to be updated, as needed, and be submitted with the PSS.~~

~~All sections of the Part II: The Personal Profile should be reviewed to ensure all sections are accurate and current. All questions in the Person Centeredness Section must be addressed. The Shared Planning Section is to be updated/changed according to information gathered during the PSS meeting. Everyone who attends the recertification PSS meeting must get a copy of the revised PSS and the signature page.~~

~~Providers should bring copies of their Activity Support Plans to the meeting to review, also. The provider has 30 days from receipt of the PSS to complete revisions the Activity Support Plan. It must be submitted to the SC/TCM by the 15th of the month following the month it is developed.~~

~~*The Plan of Services and Supports Instructions include person centered concepts, principles and materials used with permission from The Learning Community for Person Centered Practices. Find out more at www.learningcommunity.us. Support Development Associates, Inc. also contributed to development of the PCT Skills©.*~~

~~Plan of Services and Supports~~ ~~Status:~~ ~~Program Type: ID/DD~~

~~Overview~~

~~Active:~~		**~~Created Date:~~**	
~~PSS Type:~~	~~Initial/Recertification/Change~~	**~~Effective Date:~~**	
~~Service Type~~		**~~End Date:~~**	

~~Comments:~~

~~Part I - Essential Information~~

~~Contact Information~~

~~Legal First Name:~~	**~~Medicaid #~~**
~~Legal Last Name:~~	**~~Initial Certification Date:~~**
~~Legal Middle Name:~~	**~~Home Phone:~~**
~~Preferred Name:~~	**~~Cell Phone:~~**
~~Date of Birth:~~	**~~Email:~~**
~~Address:~~	**~~Support Coordinator/TCM~~**

~~Family Contact~~

~~First Name:~~	**~~Phone:~~**
~~Last Name:~~	**~~Fax:~~**
~~Middle Name:~~	**~~Email:~~**
~~Contact Type:~~	**~~Address:~~**

~~First Name:~~	**~~Phone:~~**
~~Last Name:~~	**~~Fax:~~**
~~Middle Name:~~	**~~Email:~~**
~~Contact Type:~~	**~~Address:~~**

~~First Name:~~	**~~Phone:~~**
~~Last Name:~~	**~~Fax:~~**
~~Middle Name:~~	**~~Email:~~**
~~Contact Type:~~	**~~Address:~~**

~~ID/DD Waiver Supports~~

~~Service Information~~

~~Service Type:~~ ~~PSS Service:~~
~~Frequency Type:~~ ~~Units per month:~~
~~Hours per Month:~~ ~~Rate:~~
~~Minutes:~~ ~~Costs:~~
~~How/When Support is Used:~~

~~Provider Information~~

~~Provider Name:~~ ~~Provider Number:~~
~~Contact Name:~~ ~~Phone:~~
~~Address:~~ ~~Email address~~

~~Service Information~~

~~Service Type:~~ ~~PSS Service:~~
~~Frequency Type:~~ ~~Units per month:~~
~~Hours per Month:~~ ~~Rate:~~
~~Minutes:~~ ~~Costs:~~
~~How/When Support is Used:~~

~~Provider Information~~

~~Provider Name:~~ ~~Provider Number:~~
~~Contact Name:~~ ~~Phone:~~
~~Address:~~ ~~Email address~~

~~PSS Costs~~

~~Annual Waiver Plan Services Total:~~
~~Annual 1915(i) Services Total:~~
~~Total PSS Budget:~~

~~Non – Waiver Agency Supports~~

~~Agency~~	~~Contact Name~~	~~Phone Number:~~	~~Non-Waiver Agency Support~~	~~How/When Support Provided~~

~~Natural Supports~~

~~**Are there natural supports?** Yes/No~~

~~Support Person~~	~~Relationship~~	~~Support Role~~	~~Phone Number~~

~~Medical Information~~

~~Physician~~	~~Specialty~~	~~Address~~	~~Phone~~

~~Medications~~

~~**Medications required?**~~

~~Recent Physical and Health Conditions~~

~~Recent Physical Complaints and/or Health Conditions~~

~~**Chronic health conditions?**~~	~~**Yes**~~	~~**No**~~	~~**Description:**~~
~~**History of health problems/issues?**~~	~~**Yes**~~	~~**No**~~	~~**Description:**~~
~~**Current limitations or restrictions on physical activities?**~~	~~**Yes**~~	~~**No**~~	~~**Description:**~~
~~**Any serious illnesses and/or hospitalizations in the past year including ER visits?**~~	~~**Yes**~~	~~**No**~~	~~**Description:**~~
~~**Admissions to ICF/IID, Mental Health Facilities, Rehabilitation Facilities or other inpatient care?**~~	~~**Yes**~~	~~**No**~~	~~**Description:** *(when, where, why)*~~

~~Latest Exam Dates~~

~~**Date of my last physical exam:**~~	~~**Date of my last dental exam:**~~
~~**Estimated/approximate date?**~~	~~**Estimated/Approximate date?**~~
~~**Examination Results**~~	~~**Examination Results**~~

~~**Allergies:**~~

~~**Reactions:**~~

~~Medical Support Needs and Mental Health Support Needs~~

~~**Medical Support Needs**~~	~~**Mental Health Support Needs**~~

~~Communication, Adaptive Equipment, Assistive Technology and/or Modifications~~

~~**Method(s) of communication:**~~

~~**Describe supports needed for communication (if any):**~~

~~**Describe any adaptive equipment or assistive technology supports used:**~~

~~**How is equipment maintained? Who is responsible?**~~

~~**What is the back-up plan for power outages if medical equipment is used?**~~

~~**Describe any environmental modifications necessary:**~~

~~Risk Assessment~~

~~**Date Created:**~~	~~**Risk:**~~	~~**Resolution**~~

~~Back-up and Emergency Plans~~

~~**Steps to take if the provider does not show up:**~~

~~**Steps to take if the day program/work or other activity is canceled, closes or you have to leave for some other reason:**~~

~~**Steps to take when a natural disaster occurs:**~~

~~**Plan for future living arrangements if something were to happen to the primary caregiver:**~~

~~Family and Current Living Arrangements~~

~~Education~~

~~**Current School**~~ ~~**Year**~~

~~**Last School Attended:**~~ ~~**Year**~~

~~**Type of Diploma/Certificate:**~~ ~~**Year:**~~

~~Employment History~~

~~**Was {name} ever employed?**~~ ~~Yes No~~

~~**Reason why {name} isn't working:**~~

~~Volunteer Activities~~

~~**Did {name} ever volunteer?**~~ ~~Yes No~~

~~Behavior Supports~~

~~**Previous and Current Behavior Supports:**~~

~~Serious Incidents During the Past Year~~

~~Evaluation Information~~

~~**Current ICAP Date:**~~ ~~**Current ICAP Score**~~

~~**Who Completed the ICAP**~~ ~~**Current ICAP Service Level**~~

~~**Previous ICAP Date**~~ ~~**Previous ICAP Score**~~

~~**Who Completed the ICAP?**~~ ~~**Previous ICAP Service Level**~~

~~**Psychological Date:**~~

~~**Examiner Name:**~~ ~~**Examiner Agency:**~~

~~**Primary DSM Code**~~

~~**Secondary DSM Code(s)**~~

~~Essential Information completed by:~~

~~**Person:**~~ ~~**Legal Guardian:**~~

~~**Support Coordinator/Credentials:**~~ ~~**Additional Contributors:**~~

~~**Date Reviewed:**~~

~~Part II – Personal Profile~~

~~Great Things About {name}~~

~~Hopes and Dreams~~

~~Important To/For~~

~~Important TO~~	~~Important FOR~~

~~Working/Not Working~~

~~Perspectives~~

~~Things that work~~	~~Things That Do Not work~~
~~__________'s Perspective:~~	~~___________'s Perspective:~~
~~Family's Perspective~~	~~Family's Perspective~~
~~Family's Perspective~~	~~Family's Perspective~~
~~Provider's Perspective~~	~~Provider's Perspective~~
~~Provider's Perspective~~	~~Provider's Perspective~~

~~Need to Know & Strengths~~

~~Things People Need to Know to Support {name} and Keep Him/Her Healthy and Safe~~

~~{Name} 's Strengths~~

~~Questions/Things to Figure Out~~

~~Question~~	~~Person Responsible~~

~~Are any referrals needed?~~

~~Yes~~ ~~No~~ ~~Explain:~~

~~Part III – Person Centeredness~~

~~Choice, Control, Restrictions/Limitations~~

~~**Were you given a choice of service(s)?**~~	~~Yes~~	~~No~~	~~Please describe:~~
~~**Were you given a choice of provider(s)?**~~	~~Yes~~	~~No~~	~~Please describe:~~
~~**Were you given a choice of living setting(s)?**~~	~~Yes~~	~~No~~	~~Please describe:~~
~~**Were you given a choice of roommate(s)?**~~	~~Yes~~	~~No~~	~~Please describe:~~
~~**Do you have control of your personal resources?**~~	~~Yes~~	~~No~~	~~Please describe:~~
~~**Are you given a choice of activities in your living setting?** *(including where you want to go in the community)*~~	~~Yes~~	~~No~~	~~Please describe:~~
~~**Are you given a choice of activities in your day program setting?** *(including where you want to go in the community)*~~	~~Yes~~	~~No~~	~~Please describe:~~
~~**Do you have any restrictions or limitations set by staff?** *(including visitors and food)*~~	~~Yes~~	~~No~~	~~Please describe:~~

~~Contributors Not at Meeting~~

~~Support Person~~	~~Relationship~~	~~Date contributed~~

~~Signatures~~

~~Type~~	~~Name~~	~~Services~~	~~Signature Name~~	~~Signature Date~~

~~Part IV - Shared Planning~~

~~Desired Outcome~~	~~Supports~~	~~How Often~~	~~Start Date~~	~~End Date~~

~~IDD Activity Support Plan~~

~~Purpose~~

~~The purpose of the Activity Support Plan (ASP) is to document activities and strategies/support instructions to be completed in order for a person to work towards reaching their desired outcomes as documented in the Plan of Services and Supports. Staff should be able to read a person's ASP and know exactly how to provide services and supports to that person.~~

~~General~~

~~An ASP is required for each service a person receives. Providers are responsible for developing the ASP with the person and legal/representative after the development of the Plan of Services and Supports (PSS). The ASP is tailored to the outcomes developed during a person's PSS meeting. Each service will have a separate ASP regardless of whether or not the same provider is providing more than one service.~~

~~The Support Coordinator/Targeted Case Manager must ensure all ASPs are consistent and include activities that were identified to meet the outcomes developed during the PSS meeting. If the Support Coordinator/Targeted Case Manager finds the ASP does not reflect what was discussed at the PSS meeting, he/she can return it to the provider for revision.~~

~~Outcome Statement~~

~~Providers write the outcome statements from the Shared Planning section of the PSS that pertain to the service/support they provide. Outcomes may be on more than one ASP if both services can provide support in reaching the outcome.~~

~~Person's Support Activities~~

~~List the support activities a person will participate in to assist him/her in meeting his/her stated outcomes. Activities are things that can be seen and counted. They include some sort of action word, relate to the desired outcome being addressed and are appropriate to the service/support being provided. There may be multiple support activities for each outcome.~~

~~Strategies/Support Instructions~~

~~The Strategies/Support Instructions describe how supports will be provided based on the person's choices and preferences. The strategies/support instructions will provide detailed directions for staff to follow when completing support activities with the person. The strategies/support instructions may include what the person likes to do, the type of support needed, specific directions for staff to follow, teaching steps, what is needed for success. The information must be very detailed and specific to each person and each outcome.~~

~~The ASP includes how often activities will be conducted/completed as decided upon during the PSS Development meeting. In order to track progress and collect data, each outcome must be completed/done a certain number of days per week or days per month. If an outcome is addressed daily, the number of times per day does not need to be indicated.~~

~~Once the provider receives the approved PSS, they develop the Activity Support Plan with the~~

~~person/legal representative within 30 days of certification date.~~

~~Timelines~~

~~For ID/DD Waiver and IDD CSP providers, Activity Support Plans must be developed with the person/legal guardian (if applicable) within thirty (30) days of receipt of the person's PSS. The ASP is to be submitted to the appropriate Support Coordinator/Targeted Case Manager by the 15th of the month following development. It must be reviewed and/or revised at least annually, as changes are needed or whenever the person wishes to revise it.~~

~~Other IDD services – The Activity Support Plan is to be developed with the person/legal guardian (if applicable) within 30 days of the date of the PSS and be in the person's record no later than the 10th of the month following development. It must be reviewed and/or revised at least annually, as changes are needed or whenever the person wishes to revise it.~~

~~The Support Coordinator must ensure all ASPs are consistent and include activities that were identified to meet the outcomes developed during the PSS meeting. If the Support Coordinator does not feel the ASP reflects what was discussed in the PSS meeting, he/she can send it back and request clarification. The ASP must be reviewed and/or revised at least annually, as changes are needed or whenever the person wishes to revise it.~~

~~Copies of ASPs must be available to staff at all times.~~

~~Questions/Things to Figure Out~~

~~List questions/ideas/things discussed in the PSS meeting that need to be addressed but cannot be decided upon at the meeting or that require research or additional information to figure out. There must be a person responsible assigned to address each item. There must also be timelines for accomplishing the activity.~~

~~Signatures~~

~~The ASP is developed with the person/legal representative and signed at the time of development/review. Staff developing the plan with the person/legal representative sign (including credentials) and date the plan.~~

~~IDD Activity Support Plan~~

~~Name:______________________Medicaid #:___________________Agency: ___________________ Service: ________________~~

~~(Use as much space as necessary)~~

~~Outcome Statement~~	~~List the support activities for each desired outcome~~	~~Support Instructions~~ ~~Describe how supports need to be tailored to the person's preferences and profile~~	~~How often or by when?~~

~~IDD Activity Support Plan~~

~~Name:~~______________________ ~~Medicaid #:~~____________________ ~~Agency:~~ ____________________ ~~Service:~~ ________________

~~Questions/Things to Figure Out~~ ~~(use as many lines as necessary)~~				
~~1.~~	~~Person Responsible:~~		~~By when:~~	
~~2.~~	~~Person Responsible:~~		~~By when:~~	

~~Signatures~~	
~~Person:~~	~~Date:~~
~~Legal Representative:~~	~~Date:~~
~~Provider Signature/Credentials:~~	~~Date:~~

~~IDD Service Notes~~

~~Purpose~~

~~IDD Service Notes are used to document activities that take place during the provision of services. Documentation must be detailed and specific to each person's Activity Support Plan. Staff activities toward the provision of services must also be documented. A single form can be used for one (1) or two (2) days, depending on the amount of information; use as many pages as necessary to adequately document the information each day/time services are provided. For example, if a person goes out to participate in a community activity, two (2) notes may be necessary for that day: one (1) for program site activities and one (1) for community activities.~~

~~General~~

~~Indicate the person's name, Medicaid number (or other ID number if the person does not receive Medicaid), the name of the service and the name of the agency providing the service. Document the date of service, the time it begins (using a.m./p.m.), the time it ends (using a.m./p.m.), and the total time spent providing services. Staff providing the service must sign indicating his/her credentials and date the form.~~

~~IDD Service Notes replace Activity Notes. IDD Service Notes are required for the following IDD services:~~

- ~~Behavior Support *(Each time services are provided. A separate form for detailed observation may be used if desired.)*~~
- ~~Early Intervention *(Each time services are provided.)*~~
- ~~Home and Community Supports *(Each time services are provided.)*~~
- ~~In Home Respite *(Each time services are provided)*~~
- ~~Host Homes *(Daily)*~~
- ~~Job Discovery *(Each time services are provided.)*~~
- ~~Supervised Living *(Daily - There must be a Service Note for each shift.)*~~
- ~~Supported Employment *(Each time services are provided.)*~~
- ~~Shared Supported Living *(Daily)*~~
- ~~Supported Living *(Each time services are provided.)*~~

~~IDD Service Notes must reflect who, what, when, where, how and why for activities each day/ time services are provided. The following must be specifically addressed:~~

- ~~Activities in which the person chose to participate~~
- ~~Where all activities occurred *(at the program site, in the community[list the specific location of the activity], in the home)*~~
- ~~How and why activities were completed *(this relates activities back to the person's Activity Support Plan)*~~
- ~~What worked well about the activity(ies) and what the person liked~~
- ~~What did not work well about the activity(ies) and what the person did not like~~
- ~~Staff followed during the provision of services~~
- ~~Progress toward meeting stated outcomes~~

~~IDD Service Notes must also be used to document the following:~~

- ~~When supports are not provided according to the Activity Support Plan~~
- ~~Why a person chose not to participate in an activity~~

- ~~Unusual events/circumstances~~
- ~~Why a person is absent on any given day~~
- ~~Phone calls or interaction with family or other providers/entities on behalf of the person~~

~~Service notes can be written or typed. Use as much space as necessary to completely document all activities.~~

~~Timelines~~

~~IDD Service Notes must be completed the day services are provided and be in the person's record no later than the 10th day of the month following the month service are provided.~~

IDD Service Note

Name: ______________________ **Medicaid #:** ______________________

Service: ______________________ **Agency:** ______________________

Date: **Begin Time:** **End Time:** **Total Time:** **Location(s):**

Person's Activities	**Staff's Activities**
(Who, What, When, Where, How, Why)	
Staff Signature/ Credentials	

Date: **Begin Time:** **End Time:** **Total Time:** **Location(s):**

Person's Activities	**Staff's Activities**
(Who, What, When, Where, How, Why)	
Staff Signature/ Credentials	

~~IDD Weekly Service Note~~

~~Purpose~~

~~IDD Weekly Service Notes are used to document activities that take place during the provision of services. Documentation must be detailed and specific to each person's Activity Support Plan. Staff activities toward the provision of services must also be documented.~~

~~General~~

~~Indicate the person's name, Medicaid number (or other ID number if the person does not receive Medicaid), the name of the service and the name of the agency providing the service. Document the date of service, the time it begins (using a.m./p.m.), the time it ends (using a.m./p.m.), and the total time spent providing services. Staff providing the service must sign indicating his/her credentials and date the form.~~

~~IDD Weekly Service Notes are required for the following IDD services:~~

- ~~Community Respite *(Each time services are provided.)*~~
- ~~Day Habilitation *(Daily)*~~
- ~~Day Services Adult *(Daily)*~~
- ~~Prevocational Services *(Daily)*~~
- ~~Work Activity *(Daily)*~~

~~IDD Weekly Service Notes must reflect who, what, when, where, how and why for activities each week services are provided. The following must be specifically addressed:~~

- ~~Activities in which the person chose to participate~~
- ~~Where all activities occurred *(at the program site, in the community[list the specific location of the activity], in the home)*~~
- ~~How and why activities were completed *(this relates activities back to the person's Activity Support Plan)*~~
- ~~What worked well about the activity(ies) and what the person liked~~
- ~~What did not work well about the activity(ies) and what the person did not like~~
- ~~Staff followed during the provision of services~~
- ~~Progress toward meeting stated outcomes~~

~~IDD Weekly Service Notes must also be used to document the following:~~

- ~~When supports are not provided according to the Activity Support Plan~~
- ~~Why a person chose not to participate in an activity~~
- ~~Unusual events/circumstances~~
- ~~Why a person is absent on any given day~~
- ~~Phone calls or interaction with family or other providers/entities on behalf of the person~~

~~Service notes can be written or typed. Use as much space as necessary to completely document all activities.~~

~~Timelines~~

~~IDD Weekly Service Notes must be completed the week services are provided and be in the~~

~~person's record no later than the 10th day of the month following the month service are provided.~~

~~Monthly Summary~~

~~At the end of the month, a summary of progress or lack of progress toward outcomes must be documented.~~

~~Staff completing the Weekly Progress Note must sign and date the form at the end of the month.~~

~~IDD Weekly Service Note~~

~~Name~~ ____________________

~~ID Number~~ ____________________

~~Service~~ ____________________

~~Attendance during month of~~ ~~in the year of~~

~~Days~~	~~1~~	~~2~~	~~3~~	~~4~~	~~5~~	~~6~~	~~7~~	~~8~~	~~9~~	~~10~~	~~11~~	~~12~~	~~13~~	~~14~~	~~15~~	~~16~~	~~17~~	~~18~~	~~19~~	~~20~~	~~21~~	~~22~~	~~23~~	~~24~~	~~25~~	~~26~~	~~27~~	~~28~~	~~29~~	~~30~~	~~31~~
~~Time In~~																															
~~Time Out~~																															
~~Total Time~~																															

~~Weekly Dates~~	~~Summary of Activity~~
~~1st Week~~	~~Outcomes:~~
~~Date:~~	~~Signature/Credential:~~
~~2nd Week~~	~~Outcomes:~~
~~Date:~~	~~Signature/Credential:~~

~~3rd Week~~	~~Outcomes:~~
~~Date:~~	~~Signature/Credential:~~
~~4th Week~~	~~Outcomes:~~
~~Date:~~	~~Signature/Credential:~~
~~5th Week~~	~~Outcomes:~~
~~Date:~~	~~Signature/Credential:~~
~~Monthly Summary~~	
~~Date:~~	~~Staff Signature/Credential:~~
~~Date:~~	~~Supervisor Signature/Credential:~~

~~ID/DD Waiver/IDD CSP Service Authorization~~

~~Purpose~~

~~To inform a provider what type and amount of ID/DD Waiver and IDD CSP service(s) they are authorized to provide to an individual and the begin and end dates for the authorization.~~

~~The provider receives this form from the Support Coordinator/ Targeted Case Manager.~~

~~General~~

~~Initially and when updated, the Support Coordinator/ Targeted Case Manager sends the most current Social and Psychological Reports from the Diagnostic and Evaluation Team with the Service Authorization. The Support Coordinator also sends the most current Medical Evaluation.~~

~~Timelines~~

~~No service can begin before the start date on the Service Authorization. Before any services can begin, the provider must review the Social, Medical and Psychological Reports from the Diagnostic and Evaluation Team and document the review in the Service Notes in the individual's record.~~

~~The Support Coordinator/ Targeted Case Manager must issue the Service Authorization(s) to the providers chosen by the individual and listed on the Plan of Services and Support within five (5) days of receipt of the approved certification/change(s) from the BIDD.~~

1. ~~Initial Certification/Readmission – The Support Coordinator/ Targeted Case Manager will issue Service Authorization(s) within five (5) days of receipt of the approved initial certification/readmission request.~~

2. ~~Changes – If, during the individual's certification year, there is a change in the type/amount of service a person receives, the Support Coordinator/ Targeted Case Manager will send the provider an updated Service Authorization indicating there are changes within five (5) days of receipt of the Plan of Services and Supports from the BIDD. The Service Authorization will have the new type(s) and/or amount(s) of services being authorized along with the end date of the previously authorized types(s) and/or amount(s) of service.~~

3. ~~Recertification – Annually, within five (5) days of receiving an individual's approved recertification, the Support Coordinator/ Targeted Case Manager issues a new Service Authorization to the provider(s) reflecting the services and the amount(s) of service(s) the agency is authorized to provide. The effective date of the Service Authorization will be the individual's certification begin date and the end date will be the certification lock-in end date.~~

~~If the Support Coordinator / Targeted Case Manager does not receive a signed copy of the~~

~~Service Authorization from an agency within ten (10) days, the Support Coordinator/ Targeted Case Manager will ask the individual if he/she would like to be referred to another provider. At that time, the Support Coordinator / Targeted Case Manager sends the agency a Service Authorization with an end date for the service(s).~~

~~Another Service Authorization is issued for the next agency chosen. The start date for that agency must be no sooner than the end date of the previous Service Authorization.~~

~~Start and End Dates~~

~~All service amounts/frequencies will have an authorized start and end date. Service Authorizations are valid only for the dates listed on the form. The end date cannot exceed the person's current certification lock-in end date, regardless of the authorized start date.~~

1. ~~Authorized Start Date~~
   a. ~~The date of the individual's certification, regardless of type~~
   b. ~~Date changes to the Plan of Services and Supports are approved by BIDD~~

2. ~~End Date~~
   a. ~~Initial/readmission/recertification – The certification lock-in end date~~
   b. ~~Changes – The day the BIDD approves changes to the Plan of Services and Supports~~
   c. ~~When a service is terminated~~

~~If at any time a person chooses to change providers of in home services, the Service Authorization will be effective on the 1st day of the month following the request unless the Support Coordinator can obtain documentation of the amount of services provided thus far in the month.~~

~~Exceptions:~~

a. ~~Suspected abuse or neglect or other situations in which the individual's health and welfare are at risk~~

b. ~~The individual is not receiving/has not received the particular service during the month in which the cha nge in provider is requested.~~

~~Signature of Authorized Agency Representative~~

~~An authorized agency representative must sign and date the form to verify the information is accurate and return a copy to the appropriate Support Coordinator/ Targeted Case Manager BEFORE services can begin.~~

~~The Support Coordinator/ Targeted Case Manager must sign and date the form when received from the agency.~~

~~ID/DD Waiver~~
~~Service Authorization~~

~~To:~~ ______________________ ~~From:~~ ______________________

~~Name of Agency~~ | ~~Support Coordination Department~~

~~Re:~~ ______________________ ______________________

~~Individual's Name~~ | ~~IDD Waiver Support Coordinator~~

______________________ ______________________

~~Medicaid Number~~ | ~~IDD Waiver Support Coordinator Phone/e-mail~~

____

____

~~Individual's Address and Phone Number~~

☐ ~~Change in type(s)/amount(s) of service~~

~~Procedure Code~~	~~Service~~	~~Amount~~	~~Frequency~~		~~Authorized Start Date~~	~~End Date~~
			~~---~~	~~---~~		
			~~---~~	~~---~~		
			~~---~~	~~---~~		
			~~---~~	~~---~~		
			~~---~~	~~---~~		
			~~---~~	~~---~~		
			~~---~~	~~---~~		

~~ID/DD Waiver Support Coordinator Comments/Information~~

~~Can the agency provide the service(s) requested?~~ ☐ ~~Yes~~ ☐ ~~No~~

~~Agency Comments~~

______________________ ______________________

~~Signature of Authorized Agency Representative~~ | ~~Date~~

~~To Be Completed by Support Coordinator~~

______________________ ______________________

~~Date Received from Agency~~ | ~~Support Coordinator Signature~~

~~ID/DD Waiver Home and Community Supports Service Agreement~~

~~Purpose~~

~~The Home and Community Supports (HCS) Service Agreement outlines the allowable activities, rules and procedures regarding the provision of the service. The agreement indicates supports and/or activities that can and cannot be provided by staff when services are rendered.~~

~~General~~

~~The provider is responsible for reviewing the form with the person/legal representative. Both the staff person and person/legal representative must sign form to indicate agreement to adhere to the requirements in order to receive services.~~

~~Timelines~~

~~The provider reviews the Home and Community Supports Service Agreement with the person/legal representative prior to or at the time the provider begins providing services and at least annually thereafter, at the same time the Activity Support Plan is completed. A signed document must be maintained in the person's record and the person/legal representative must be given a copy to keep.~~

~~ID/DD Waiver Home and Community Supports Service Agreement~~

~~Name:~~ **~~Medicaid Number:~~**

1. ~~Home and Community Supports (HCS) will meet the support needs identified in the Plan of Services and Supports and Activity Support Plan. Only the amount of Home and Community Supports authorized in the Plan of Services and Supports will be provided. If a change in the amount is needed, the Support Coordinator must be contacted.~~
2. ~~HCS can be provided in the home and/or in the community and either with or without a parent/legal representative present, depending upon identified support needs.~~
3. ~~HCS staff cannot be responsible for caring for others who may be in the home. HCS staff is only responsible for the person who is enrolled in the ID/DD Waiver. Also, the HCS staff person is not responsible for caring for pets.~~
4. ~~HCS cannot be provided at a staff person's home.~~
5. ~~If a scheduled HCS visit must be canceled (e.g. because of a doctor's appointment, illness, going out of town, etc.), the provider must be notified as soon in advance of the cancellation as possible. Three (3) cancellations for which no notice is given will result in a review of the Plan of Services and Supports to determine if Home and Community Supports are still necessary and appropriate.~~
6. ~~HCS may be terminated according to the provisions in the ID/DD Waiver Enrollment Agreement.~~
7. ~~If a decision is made to terminate HCS, notification will be sent as soon as possible. The Support Coordinator will assist in locating other service options, if available. There are established procedures for filing an appeal of the decision. The services will not change until the outcome of the appeal is determined. If termination of services is due to the environment or persons in the environment posing a risk to the HCS staff person, services might continue pending the outcome of the appeal.~~
8. ~~Should any problems arise regarding the provision of HCS, the Support Coordinator is to be notified immediately.~~
9. ~~HCS cannot be provided on an overnight basis outside of the legal residence.~~
10. ~~HCS staff cannot provide medical treatment of any sort, as defined in the Mississippi Nurse Practice Act Rules and Regulations.~~
11. ~~Home and Community Supports staff cannot accompany a minor child on a medical visit without the parent/legal representative.~~
12. ~~HCS staff cannot provide services to someone who is in a hospital or any other facility being reimbursed by Medicaid, Medicare or private insurance.~~
13. ~~Home and Community Supports cannot be provided in a school setting.~~
14. ~~Home and Community Supports providers cannot do personal errands or have interactions with their family and friends during the provision of services.~~

~~The above information has been reviewed and the circumstances under which Home and Community Supports can be provided are understood.~~

~~Person/Legal Representative Signature~~	~~Agency Representative Signature/ Credentials~~
~~Date~~	~~Date~~

~~ID/DD Waiver In-Home Respite~~
~~Service Agreement~~

~~Purpose~~

~~The In-Home Respite Service Agreement outlines the allowable activities, rules and procedures regarding the provision of the service. The agreement indicates supports and/or activities that can and cannot be provided by staff when services are rendered.~~

~~General~~

~~The provider is responsible for reviewing the form with the person/legal representative. Both the staff person and person/legal representative must sign form to indicate agreement to adhere to the requirements in order to receive services.~~

~~Timelines~~

~~The provider reviews the In-Home Respite Service Agreement with the person/legal representative prior to or at the time the provider begins providing services and at least annually thereafter, at the same time the Activity Support Plan is completed. A signed document must be maintained in the person's record and the person/legal representative must be given a copy to keep.~~

~~ID/DD Waiver In-Home Respite Service Agreement~~

~~Name:~~	~~Medicaid Number:~~

1. ~~In-Home Respite will meet the support needs identified in the Plan of Services and Supports and Activity Support Plan. Only the amount of In-Home Respite authorized in the Plan of Services and Supports will be provided. If a change in the amount is needed, the Support Coordinator must be contacted.~~
2. ~~In-Home Respite is to be provided in the home. The provider can take the person on short (1-2 hour) community outings to get out of the house for a short period, but community participation cannot be the purpose of the service.~~
3. ~~In-Home Respite staff cannot be responsible for caring for others who may be in the home. In-Home Respite staff is only responsible for the person who is enrolled in the ID/DD Waiver. Also, the In-Home Nursing Respite staff person is not responsible for caring for pets.~~
4. ~~If a scheduled In-Home Respite visit must be canceled (e.g. because of a doctor's appointment, illness, going out of town, etc.), the provider must be notified as soon in advance of the cancellation as possible. Three (3) cancellations for which no notice is given will result in a review of the Plan of Services and Supports to determine if In-Home Respite is still necessary and appropriate.~~
5. ~~In-Home Respite may be terminated according to the provisions in the ID/DD Waiver Enrollment Agreement.~~
6. ~~If a decision is made to terminate In-Home Respite, notification will be sent as soon as possible. The Support Coordinator will assist in locating other service options, if available. There are established procedures for filing an appeal of the decision. The services will not change until the outcome of the appeal is determined. If termination of services is due to the environment or persons in the environment posing a risk to the In-Home Respite staff person, services might continue pending the outcome of the appeal.~~
7. ~~Should any problems arise regarding the provision of In-Home Respite, the Support Coordinator is to be notified immediately.~~
8. ~~In-Home Respite staff cannot provide medical treatment of any sort, as defined in the Mississippi Nurse Practice Act Rules and Regulations.~~
9. ~~In-Home Respite staff cannot accompany anyone on a medical visit.~~
10. ~~A relative may only provide up to 172 hours of In-Home Respite per month.~~
11. ~~In-Home Respite providers cannot do personal errands or have interactions with their family and friends during the provision of services.~~

~~The above information has been reviewed and the circumstances under which In-Home Respite can be provided are understood.~~

~~Person/Legal Representative Signature~~	**~~Agency Representative Signature/Credentials~~**
~~Date~~	**~~Date~~**

~~ID/DD Waiver In-Home Nursing Respite Service Agreement~~

~~Purpose~~

~~The In-Home Nursing Respite Service Agreement outlines the allowable activities, rules and procedures regarding the provision of the service. The agreement indicates supports and/or activities that can and cannot be provided by staff when services are rendered.~~

~~General~~

~~The provider is responsible for reviewing the form with the person/legal representative. Both the staff person and person/legal representative must sign form to indicate agreement to adhere to the requirements in order to receive services.~~

~~Timelines~~

~~The provider reviews the In-Home Nursing Respite Service Agreement with the person/legal representative prior to or at the time the provider begins providing services and at least annually thereafter, at the same time the Activity Support Plan is completed. A signed document must be maintained in the person's record and the person/legal representative must be given a copy to keep.~~

~~ID/DD Waiver In-Home Nursing Respite~~
~~Service Agreement~~

~~Name:~~	**~~Medicaid Number:~~**
	~~Agency:~~

1. ~~In-Home Nursing Respite (IHNR) services will meet the support needs identified in the Plan of Services and Supports and Activity Support Plan. Only the amount of In-Home Nursing Respite authorized in the Plan of Services and Supports will be provided. The Support Coordinator must be contacted if a change in the amount is needed.~~
2. ~~IHNR is provided by either a Licensed Practical Nurse (LPN) or Registered Nurse (RN). The service is intended to be temporary (short-term) and provide periodic relief to the primary caregiver.~~
3. ~~IHNR is provided in the family home either with or without a parent/legal guardian present, depending upon identified support needs.~~
4. ~~IHNR services cannot be provided in the nurse's or any of his/her relatives' homes.~~
5. ~~Nurses are NOT responsible for caring for others who may be in the home. The nurse is only responsible for the person who is enrolled in the ID/DD Waiver. Also, the nurse is not responsible for caring for pets.~~
6. ~~If a scheduled time for IHNR must be canceled (e.g. because of a doctor's appointment, illness, going out of town, etc.) the nurse must be notified as soon in advance of the cancellation as possible. Three (3) cancellations for which no notice is given will result in a review of the Plan of Services and Supports to determine if IHNR services are still necessary and appropriate.~~
7. ~~It is understood that the IHNR staff person will complete all forms necessary to document the provision of IHNR. I or my parent/legal representative will be asked to initial the Service Note each time IHNR services are provided to verify that the provider provided the amount of service indicated. It is understood that signing false or fraudulent documentation is against the law.~~
8. ~~If a decision is made to terminate IHNR services because of failure to adhere to the ID/DD Waiver Enrollment Agreement or the IHNR Service Agreement, notification will be sent as soon as possible. The Support Coordinator will assist in locating other service options, if available. There are established procedures for filing an appeal and those will be provided. The services will not change until the outcome of any appeal is determined. If the environment or persons in the environment pose a risk to the IHNR staff person, he/she/the agency does not have to continue providing services.~~
9. ~~Should any problems arise regarding the provision of IHNR, notify the Support Coordinator immediately to avoid possible interruption of services.~~
10. ~~Medical treatment provided by nurses must be completed according to the Mississippi Nurse Practice Act Rules and Regulations. Any questions regarding nurses and their scope of practice must be addressed directly to the Mississippi Board of Nursing.~~

~~The above information has been reviewed and the circumstances under which In-Home Nursing Respite Services can be provided are understood.~~

~~Person/Legal Representative Signature~~	**~~Agency Representative Signature/Credentials~~**
~~Date~~	**~~Date~~**

~~IDD Waiver In-Home Nursing Respite Service Note~~

~~Purpose~~

~~The provider must document on the In-Home Nursing Respite Service Note time spent in service provision with the person receiving supports. In-Home Nursing Respite Service Notes must reflect activities and strategies written in the Activity Support Plan.~~

~~General~~

~~Nurses are governed by the Mississippi Board of Nursing and the Mississippi Nurse Practice Act and Rules and Regulations. For purposes of the ID/DD Waiver, the In-Home Nursing Respite Service Note must have information sufficient enough to justify the time spent providing the service. The In-Home Nursing Respite Service Note must identify the time services began, the time they ended (indicating a.m./p.m.) and the total amount of time spent providing services. The person/legal representative must sign the note verifying the services documented were provided during the times indicated.~~

~~In-Home Nursing Respite Service Notes must be completed during service provision. The nurse completing the In-Home Nursing Respite Service Note signs and dates it at the completion of the shift.~~

~~Timelines~~

~~In-Home Nursing Respite Service Notes must be in the person's record no later than the 10th day of the month following the month they were completed.~~

~~IDD Waiver In-Home Nursing Respite Service Note~~

~~Name~~ ______________________

~~Agency~~ ______________________

~~ID Number~~ ______________________

~~Page~~ ~~of~~

~~Provider's Signature/Credentials~~	~~Date (m/d/yr)~~	~~Time In (am/pm)~~	~~Time Out (am/pm)~~	~~Total Time~~	~~Person/Legal Representative's Signature~~

~~Notes~~

~~IDD Employment Profile~~

~~Purpose~~

~~The IDD Employment Profile is used for people who have not had or who do not wish to participate in Job Discovery. The IDD Employment Profile is used to determine a person's skills, interests and preferences as they relate to a career path or field of employment. This information serves as the basis of job searching for the person.~~

~~General~~

~~Information gathered is used to determine the best job fit for someone. The Employment Specialist/Job Coach is to use this information when assisting a person in locating a job. The information can be relayed to potential employers in order to help facilitate obtaining a job in which the person can be satisfied and successful.~~

~~If a person referred to a Supported Employment provider already has a job, this form would not need to be completed. It would be completed at such time as when the person desires a new job or is terminated from his/her current job.~~

~~Information to Be Gathered~~

~~Address each area with the person and/or someone who knows him/her best if he/she does not speak using words. This information can be gathered by the Program Supervisor or a Direct Support Staff person.~~

~~Timelines~~

~~The IDD Employment Profile is to be completed within thirty (30) days of enrollment in a Supported Employment program and is to be updated if a person loses/changes jobs. The purpose of the update is to ensure any changes in the information are reflected. For instance, a person may find after working for several months that he/she likes a more interactive work environment than when he/she first started or he/she may gain skills that would need to be reflected when looking for another job. The IDD Employment Profile must be in the person's record by the 10th of the month following the month in which it is completed.~~

~~ID/DD Waiver/IDD Community Support Program~~

~~The IDD Employment Profile must be submitted to the person's ID/DD Waiver Support Coordinator or IDD Community Support Program Targeted Case Manager by the 15th of the month following the month it is completed. The information gathered from the IDD Employment Profile may be used to update the Plan of Services and Supports and generate new outcome(s) for the person. A Team Meeting may be necessary and provider staff will be required to attend.~~

IDD Employment Profile

Name: ____________________
ID Number: ____________________
Date: ____________________
Provider Agency: ____________________

Availability:

☐ Weekdays ☐ Evenings ☐ Full time (40 hours/week)
☐ Weekends ☐ Part-time (at least 20 hrs/week) ☐ Less than part-time (less than 20 hrs/week)

Transportation:

☐ Needs transportation ☐ Needs assistance/training to access public transportation
☐ Can access public transportation ☐ Family/neighbor/friend/co-worker will transport

Financial Situation:

☐ Income must not affect benefits ☐ Financial ramifications not an obstacle
☐ Is concerned/would like more information about increased income effect on SSI/SSDI

Time awareness:

☐ Cannot tell time ☐ Understands break and lunch
☐ Can tell exact time ☐ Can tell time to the hour
☐ Must have digital clock/watch to tell time ☐ Can tell time with analog clock/watch

Lifting ability:

☐ 0-5 lbs. ☐ 10-20 lbs.
☐ 20+ lbs. ☐ Cannot lift

Endurance (hours per day):

☐ 2-4 hrs, many breaks ☐ 2-4 hrs, few breaks
☐ 5-8 hrs, many breaks ☐ 5-8 hrs, few breaks

Preferred work area (check all that apply):

☐ Small area/one room ☐ Several rooms
☐ Building-wide ☐ Building and grounds

Mobility:

☐ Walks without assistance ☐ Requires adaptations/assistance to walk/stand
☐ Uses a wheelchair/must be pushed ☐ Uses a wheelchair/can self-navigate

Supervision (check all that apply):

☐ Requires one-on-one supervision/all times ☐ Can be unsupervised for 30 minutes
☐ Can be unsupervised for 60 minutes ☐ Does not require immediate supervision
☐ Prefers to work alone ☐ Likes to be a part of a team of 3 or less
☐ Likes to work in larger groups

Adapt to change/ability to follow rules:

☐ Accepts change ☐ Does not adapt to change ☐ Does not like change
☐ Prefers routine tasks ☐ Prefers variety of tasks ☐ Flexible
☐ Follows variety of rules ☐ Must have assistance to follow rules

Multitask (check all that apply):

☐ Can complete 1-3 tasks in sequence independently ☐ Can complete 1-3 tasks in sequence with assistance
☐ Can complete 4-6 tasks in sequence independently ☐ Can complete 4-6 tasks in sequence with assistance
☐ Can complete more than 7 tasks independently ☐ Can complete more than 7 tasks with assistance

Self-initiation:

☐ Always requires prompting to move to next step ☐ Will ask for next step 25% of the time
☐ Will ask for next step 25%-50% of the time ☐ Will ask for next step more than 50% of the time

Benefits desired (check all that apply):

☐ None ☐ Vacation ☐ Vision
☐ Medical ☐ Dental

~~IDD~~
~~Employment Profile~~

~~Name:~~ ____________________
~~ID Number:~~ ____________________
~~Date:~~ ____________________
~~Provider Agency:~~ ____________________

~~Interactions/Preferred Work Environment (check all that apply):~~

- ☐ ~~Friendly, talkative co-workers~~
- ☐ ~~Helps others (co-workers, customers)~~
- ☐ ~~Receives satisfaction from completing tasks~~
- ☐ ~~Prefers a relaxed work site~~
- ☐ ~~Would like to advance in the company~~
- ☐ ~~Prefers few interactions with co-workers~~
- ☐ ~~Prefers busy, high demand work site~~
- ☐ ~~Prefers very quiet work site~~
- ☐ ~~Requires recognition for a job well done~~

~~Person has expressed interest in:~~

~~Things done to earn money in the past:~~

~~Short term jobs(less than 90 days):~~

~~Describe any interactions/services from MDRS (include dates and activities)~~

~~Volunteer or internship experiences:~~

~~Describe favorite employment experience (if applicable):~~

~~Describe work skills the person already has:~~

~~How does the person get around in the community:~~

~~IDD~~ ~~**Employment Profile**~~	~~**Name:**~~ ______ ~~**ID Number:**~~ ______ ~~**Date:**~~ ______ ~~**Provider Agency:**~~ ______
~~**What are the person's hobbies and interests:**~~	
~~**What are the person's preferred conditions (non- negotiations) for employment at this time:**~~	
~~**What are the person's potential contributions to offer to employers:**~~	
~~**Staff signature/credentials**~~	

~~ID/DD Waiver Job Discovery Profile~~

~~Purpose~~

~~The Job Discovery Profile is developed as a result of the Job Discovery Process and contains information that provides a full and accurate picture of the person.~~

~~General~~

~~The Job Discovery Profile should be written in positive, person-first language that portrays the person in the best light possible. While a specific form is not required, all elements listed below must be addressed.~~

~~Part I~~

~~Identification information~~ *~~(birthdate, gender, address, phone number(s), Medicaid Number, Social Security Number, place of residence, name of parent/legal representative, address and phone number, if different than the person's, marital status, additional agencies involved with the person and what they provide and/or agencies involved with the family and what they provide. The PSS can be used to gather some of this information.)~~*

~~Living Arrangements~~

a. ~~Family members involved in the person's life, including extended family in the local area~~
b. ~~Names, ages and employment (if applicable) of the people living in the home/residence (if applicable)~~
c. ~~Residential history~~
d. ~~Description of neighborhood~~
e. ~~Location of neighborhood in the community~~
f. ~~Transportation used by person, family, staff~~
g. ~~General commercial areas (shopping , industry, services) near the home~~

~~Education and Specialized Training History~~

a. ~~School, dates of attendance, degree/Certificate of Completion/Occupational Diploma, reason if not completed~~
b. ~~Vocational training, internships, special trainings, sheltered workshops, other day programs, dates, locations, name of entity, special skills developed, level of interest in these activities~~

~~Part II~~

~~Person and Family~~

a. ~~Brief summary~~
b. ~~Typical routine~~
c. ~~Family (or staff, as appropriate) supports~~
d. ~~Family (staff) and person's needs for daily routine support~~
e. ~~Physical and health related issues~~

~~Employment and Related Activities~~

a. ~~Informal work performed at home for others~~
b. ~~Formal chores and responsibilities~~
c. ~~Entrepreneurial activities~~
d. ~~Internships, structured work experiences, sheltered work, other day programs,~~

~~volunteering~~

- ~~e. Wage employment~~
- ~~f. General areas of previous work interest~~

~~Life Activities and Experiences~~

- ~~a. Friends and social groups~~
- ~~b. Personal activities including hobbies, done at home~~
- ~~c. Family/friend activities, including hobbies, done at home~~
- ~~d. Personal activities, including hobbies, done in the community~~
- ~~e. Family/friend activities, including hobbies, done in the community~~
- ~~f. Specific events and activities that are of crucial importance~~

~~Skills, Interests and Conditions in Life Activities~~

- ~~a. Domestic/home skills~~
- ~~b. Community participation skills~~
- ~~c. Recreation/leisure skills~~
- ~~d. Academic skills~~
- ~~e. Physical fitness skills~~
- ~~f. Arts and Talents~~
- ~~g. Communication skills~~
- ~~h. Social skills~~
- ~~i. Mobility skills~~
- ~~j. Sensory skills (sight, hearing, smell, touch)~~
- ~~k. Vocational skills~~
- ~~l. Personal care needs~~

~~Connections for Employment~~

- ~~a. Potential connectors in family (or staff, as appropriate)~~
- ~~b. Potential connectors among friends, neighbors, and work colleagues~~
- ~~c. Potential connection sites in community relationships~~
- ~~d. Potential connections through clubs, organizations, or groups (such as church or school)~~
- ~~e. List of local employers (determined by proximity, relationships, interest areas, etc.)~~

~~Part III~~
~~Conditions for Success~~

- ~~a. General conditions for participant~~
- ~~b. General conditions for family (or staff, as appropriate)~~
- ~~c. Conditions for task performance~~
- ~~d. Instructional strategies~~
- ~~e. Environmental conditions~~
- ~~f. Supervisory strategies~~
- ~~g. Supports needed for successful task performance~~
- ~~h. Conditions to be avoided~~

~~Interests Toward an Aspect of the Job Market~~

- ~~a. General personal interest~~
- ~~b. General family interests (or staff, as appropriate)~~
- ~~c. Activities participant engages in without being expected to do so~~

d. ~~General areas of current work interest~~
e. ~~Specific areas of past work experience~~

~~Contributions~~

a. ~~Strongest positive personality characteristics~~
b. ~~Most reliable strengths regarding performance~~
c. ~~Best current and potential skills to offer to potential employers~~
d. ~~Credential training, certifications, and recognized skills~~
e. ~~Possible sources for recommendations~~
f. ~~Resources/financial assets~~

~~Challenges~~

a. ~~Areas potentially needing matching to employment sites~~
b. ~~Areas potentially needing negotiation with local employers~~
c. ~~Physical/health restrictions~~
d. ~~Habits and routines~~
e. ~~Challenges related to disability – need for accommodation and disclosure~~
f. ~~Financial issues~~
g. ~~Transportation issues~~

~~Potential Employer List~~
~~List businesses, addresses and types of each business.~~

~~Signatures~~
~~The Job Discovery Profile must be signed and dated by the person/legal representative, Job Discovery staff, and his/her program director.~~

~~Timelines~~

~~The Job Discovery Profile is to be completed no more than three (3) months from the date of the person's referral to the Job Discovery agency. It is to be in the record by the 10th of the month following the month it is completed. Submit to the Support Coordinator by the 15th of the month following the month it is developed.~~

~~Request for ID/DD Waiver Behavior Support and/or Crisis Support Services~~

~~Purpose~~

~~The form must be completed when a person requests a Behavior Support Evaluation or Crisis Support. The form is submitted by the ID/DD Waiver Support Coordinator with input from the person, family, providers, and the chosen Behavior Support or Crisis Support provider.~~

~~General~~

~~Indicate the service being requested, the person's diagnoses, medications, targeted behaviors, the frequency of behaviors and the last occurrence and the environment(s) where the behavior(s) occurred. The form must reflect whether or not the person has received the service in the past. If the answer is yes, the previous provider and dates services were provided must be indicated.~~

~~The request for each service must be tailored to the service and the justification must support the definition of the service as indicated in the DMH Operational Standards.~~

~~Timelines~~

~~If a person is admitted to ***Crisis Support*** services prior to the service being approved on his/her Plan of Services and Supports, the Support Coordinator has five (5) days to submit a request to BIDD for approval. Behavior Support services cannot be provided prior to BIDD approval.~~

~~ID/DD Waiver Request for Behavior Support and/or Crisis Support~~

~~Name:~~		~~Date:~~	
~~Medicaid #:~~		~~Regional Program:~~	
~~Support Coordinator:~~		~~SC Phone Number:~~	
~~Service(s) Requested:~~		~~Provider Requested:~~	
~~Diagnoses:~~			
~~Current Medications:~~			
~~Target Behavior(s):~~			
~~Frequency of behavior(s):~~			
~~Date of last occurrence of behavior(s):~~			
~~Environment(s) where behavior(s) occur:~~			
~~Desired goal/outcome of service:~~			
~~Has the person received the service(s) before?~~		~~Yes~~	~~No~~
~~If so, list dates and provider(s) and reason(s) services are provided:~~			
~~Source(s) of Information:~~			

~~Support Coordinator Signature/Credentials~~	**~~Date~~**

~~❖BIDD Staff Approval❖~~

~~Medical Verification for ID/DD Waiver~~
~~Behavior Support and Crisis Intervention Services~~

~~Purpose~~

~~A physical evaluation must be conducted by a licensed physician or nurse practitioner to rule out any underlying medical conditions that may be causing the behavior(s) to occur (for example, an abscessed tooth, ulcer, ear ache etc.).~~

~~General~~

~~ID/DD Waiver Behavior Support~~

~~This form is to be completed during the Behavior Support evaluation process. During the Behavior Support Consultant's initial meeting with the person/legal representative and service provider(s), if applicable, the rationale for the form is explained. The person/legal representative/service provider is responsible for ensuring the form is completed by a physician or nurse practitioner. The physical evaluation cannot be more than ninety (90) days old at the time Behavior Support Services begin.~~

~~ID/DD Waiver Crisis Intervention~~

~~A person must see a physician/nurse practitioner as soon as feasible after the initiation of ID/DD Waiver Crisis Intervention Services to determine if there are any physical/medication factors that may be contributing to the crisis behaviors. The ID/DD Waiver Crisis Intervention Services provider is responsible for working with the person/legal representative and/or other service providers to have the form completed as soon as possible, but not to exceed ten (10) days after the initiation of ID/DD Waiver Crisis Intervention Services.~~

~~Timelines~~

~~The ID/DD Waiver Behavior Support/ID/DD Waiver Crisis Intervention provider must maintain a copy of this form in the person's record. It must be placed in there no later than the 10th of the month following the month it is signed by the physician/nurse practitioner. A copy must be forwarded to the Support Coordinator no later than the 15th of the month following the month it is completed.~~

~~Medical Verification for ID/DD Waiver~~
~~Behavior Support and Crisis Intervention Services~~

~~Person's Name:~~			
~~Healthcare Provider's Name:~~		**~~Office Phone:~~**	
~~Healthcare Provider's Address:~~			

~~Proposed Behavior Support/Crisis Intervention Service:~~

~~Healthcare Provider:~~ ~~Please initial to indicate your agreement or disagreement with each of the items listed below. If you are in disagreement with any of the statements, please summarize on the reverse side of this form your reasons for disagreeing, as well as your recommendations and/or treatment plans.~~

~~Agree~~	**~~Disagree~~**	
		~~There is no medical reason that this person cannot participate in the proposed Behavior Support/Crisis Intervention Services.~~
		~~This person presents no symptoms of physical illness that should receive medical treatment prior to starting/continuing Behavior Support/Crisis Intervention services.~~
		~~This person presents no symptoms of mental illness that should receive medical treatment prior to starting Behavior Support/Crisis Intervention services.~~
		~~There are no special medical precautions to follow during the implementation of Behavior Support/Crisis Intervention services.~~

~~Based Upon My Knowledge of This Person:~~

	~~He/she can participate in the proposed Behavior Support/Crisis Intervention services.~~
	~~He/she requires medical treatment that must be successfully completed prior to starting Behavior Support/Crisis Intervention services.~~
	~~He/she cannot participate in the proposed Behavior Support/Crisis Intervention services for medical reasons.~~

~~Signature of Healthcare Provider/Credentials~~		**~~Date~~**

~~ID/DD Waiver Functional Behavior Assessment~~

~~Purpose~~

~~To assess where the behavior(s) occurs, any antecedent(s) of the behavior(s), consequences(s) of the behavior(s), factor(s) that may be maintaining the behavior(s), frequency of the behavior(s), and how the behavior(s) impacts the person's environment and life.~~

~~General~~

~~This assessment is completed by the Behavior Support Consultant using interviews with the person, family, others, and direct observation. Observation of youth can occur in the school setting, but actual Behavior Support Services cannot be provided in the school and be billed to Medicaid.~~

~~All components must be addressed.~~

~~The Recommendations sections contains information indicating if the Behavior Support Consultant recommends a Behavior Support Plan is warranted, staff training only is warranted, or no Behavior Support Services are needed. It also indicates information regarding any referrals that may need to be made or other recommendations that can assist the person/family.~~

~~Timelines~~

~~The Functional Behavior Assessment must be completed within ninety (90) days of BIDD approval for Behavior Support Services.~~

~~Submission of Documentation~~

~~The ID/DD Waiver Functional Behavior Assessment must be submitted to the Support Coordinator along with the Behavior Support Plan and Justification for Behavior Support Services within ten (10) days of completion of the Behavior Support Plan. The Support Coordinator then submits all documentation to BIDD for review.~~

~~If the ID/DD Waiver Functional Behavior Assessment indicates a Behavior Support Plan is not warranted, but training of staff and other individuals who interact with the person is, indicate such on the Justification for Behavior Support Services.~~

~~If the ID/DD Waiver Functional Behavior Assessment indicates neither a Behavior Support Plan nor training is necessary, submit the completed ID/DD Waiver Functional Behavior Assessment to the appropriate Support Coordinator within ten (10) days of completion, along with a narrative indicating that Behavior Support Services were not warranted as per the assessment.~~

# ~~ID/DD Waiver Functional Behavior Assessment~~	**~~Name:~~**			
	~~Assessment Date(s):~~			
	~~ID Number:~~			
	~~DOB:~~		**~~Sex:~~**	~~❑M ❑F~~

~~Respondents(s):~~

~~Behavior Consultant/Credentials/Agency:~~

~~I. Description of Behavior(s)~~

~~A. What are the behavior(s) of concern? For each, define the topography (how it is performed), frequency (how often it occurs per day, week, or month), duration (how long it lasts when it occurs), and intensity (the magnitude of the behavior - low, medium, high - and if it causes harm).~~

~~Behavior and Topography:~~	**~~Frequency~~**	**~~Duration~~**	**~~Intensity~~**

~~Behavior and Topography:~~	**~~Frequency~~**	**~~Duration~~**	**~~Intensity~~**

~~Behavior and Topography:~~	**~~Frequency~~**	**~~Duration~~**	**~~Intensity~~**

~~Behavior and Topography:~~	**~~Frequency~~**	**~~Duration~~**	**~~Intensity~~**

~~B. Which of the behaviors described above occur together (e.g., occur at the same time; occur in a predictable chain; occur in response to the same situation)?~~

~~II. Ecological Events That May Affect the Behavior(s)~~

~~A. What medications is the person taking (if any), and how do you believe these may affect his/her behaviors?~~

~~B. What medical complications (if any) does the person experience that may affect his/her behavior (e.g., asthma, allergies, rashes, sinus infections, seizures, etc.)?~~

~~C. Describe the sleep cycles of the person and the extent to which these cycles affect his/her behavior.~~
~~D. Describe the eating routines and diet of the person and the extent to which these routines may affect his/her behavior.~~
~~E. Briefly list below the person's typical daily schedule of activities:~~

~~6:00 am~~		~~3:00 pm~~	
~~7:00 am~~		~~4:00 pm~~	
~~8:00 am~~		~~5:00 pm~~	
~~9:00 am~~		~~6:00 pm~~	
~~10:00 am~~		~~7:00 pm~~	
~~11:00 am~~		~~8:00 pm~~	
~~12:00 pm~~		~~9:00 pm~~	
~~1:00 pm~~		~~10:00 pm~~	
~~2:00 pm~~		~~11:00 pm~~	

~~F. Describe the extent to which you believe the activities that occur during the day are predictable for the person. (e.g., when to get up, eat dinner, shower, go to school/work, etc.)?~~
~~G. About how often does the person get to make choices about activities, reinforcers, etc.? In what areas does the person get to make choices (e.g., food, clothing, social companions, leisure activities, etc.)?~~
~~H. Describe the variety of activities performed on a typical day (exercise, community activities, etc.)~~
~~I. How many other people are in the setting (work/school/home)? Do you believe that the density of people or interactions with other persons affect the targeted behaviors?~~
~~J. If the person is attending a day program, what is the staffing pattern? To what extent do you believe the number of staff, training of staff, quality of social contacts with staff, etc., affect the targeted behaviors?~~
~~K. If not attending a day program, describe some typical interactions of the person with others in the home or other environments.~~

~~L. Are the tasks/activities presented during the day boring or unpleasant for the person, or do they lead to results that are preferred or valued?~~
~~M. If the person attends a day program, what outcomes are monitored regularly by staff (frequency of behaviors, skills learned, activity patterns)?~~
~~N. If the person does not attend a day program, how do people in the home or other environments monitor outcomes?~~

~~III. Events and Situations that Predict Occurrences of the Behavior(s)~~
~~A. Time of Day: When is the behavior(s) most likely and least likely to occur?~~ ~~Most Likely~~ ~~Least Likely~~
~~B. Setting: Where is the behavior most likely and least likely to occur?~~ ~~Most Likely~~ ~~Least Likely~~
~~C. Control: With whom is the behavior most likely and least likely to occur?~~ ~~Most Likely~~ ~~Least Likely~~
~~D. What activity is most likely and least likely to produce the behavior(s)?~~ ~~Most Likely~~ ~~Least Likely~~
~~E. Are there particular situations, events, etc., that are not listed previously that "set off" the behavior(s) that cause concern (particular demands, interruptions, transitions, delays, being ignored, etc.)?~~
~~F. What would be the one thing you could do that would be most likely to make the undesirable behavior(s) occur?~~

~~IV. Function of the Undesirable Behavior(s)~~	
~~A. Review each of the behaviors listed in Part I and define the function(s) you believe the behavior serves for the person (i.e., what does he/she get and/or avoid by doing the behavior?).~~	
~~Behavior:~~	
~~What does he/she get?~~	~~What does he/she avoid?~~
~~Behavior:~~	
~~What does he/she get?~~	~~What does he/she avoid?~~

~~Behavior:~~

~~What does he/she get?~~	~~What does he/she avoid?~~

~~Behavior:~~

~~What does he/she get?~~	~~What does he/she avoid?~~

~~B. Describe the person's most typical response to the following situations:~~

1. ~~Is the above behavior(s) more likely less likely unaffected if you present him/her with a difficult task?~~
2. ~~Is the above behavior(s) more likely less likely unaffected if you interrupt a desired event (eating ice cream, watching TV, etc.)?~~
3. ~~Is the above behavior(s) more likely less likely unaffected if you deliver a "stern" request/command/reprimand?~~
4. ~~Is the above behavior(s) more likely less likely unaffected if you are present but do not interact with him/her?~~
5. ~~Is the above behavior(s) more likely less likely unaffected if the routine is changed?~~
6. ~~Is the above behavior(s) more likely less likely unaffected if something the person wants is present but he/she cannot get to it (i.e., a desired object that is out of reach)?~~
7. ~~Is the above behavior(s) more likely less likely unaffected if he/she is alone?~~

~~V. Efficiency of the Undesirable Behavior(s)~~

~~A. What amount of physical effort is involved in the behavior(s) (e.g., prolonged intense tantrums -vs- simple verbal outbursts, etc.)?~~

~~B. Does engaging in the behavior(s) result in a "payoff" (getting attention, avoiding work) every time? Almost every time? Once in a while?~~

~~C. How much of a delay is there between the time the person engages in the behavior(s) and gets the "payoff"? Is it immediate, a few seconds, or longer?~~

~~VI. Primary Method(s) Used by the Person to Communicate~~

~~A. What are the general expressive communication strategies used by or available to the person in the following situations?~~

	~~Request attention~~	~~Request Help~~	~~Request preferred food/objects/ activities~~	~~Show you something or a place~~	~~Indicate physical pain~~	~~Indicate confusion~~	~~Protest/ reject situation~~
~~Complex speech~~							
~~Multiple words~~							
~~One word utterances~~							
~~Complex signing~~							
~~Simple signs~~							
~~Echolalia~~							
~~Pointing~~							
~~Leading~~							
~~Grab/Reach~~							
~~Increased movement~~							
~~Moves away~~							
~~Moves closer~~							
~~Fixed gaze~~							
~~Facial expressions~~							
~~Aggression~~							
~~Self-injury~~							
~~Eye movements~~							
~~Augmentative communication~~							

~~B. With regard to receptive communication:~~

1. ~~Does the person follow requests or instructions? If so approximately how many?~~

2. ~~Is the person able to imitate physical models for various tasks or activities?~~

3. ~~Does the person respond to signed or gestural requests or instructions?~~

4. ~~How does the person indicate yes or no?~~

~~VII. Events, Actions, and Objects Perceived as Positive by the Person?~~

~~A. In general, what are the things (events/activities/objects/people) that appear to be reinforcing or enjoyable for the person?~~

~~VIII. "Functional Alternative" Behaviors Known by the Person?~~

~~A. What socially appropriate behaviors/skills does the person perform that may be ways of achieving the same function(s) as the behavior(s) of concern?~~

~~B. What things can you do to improve the likelihood that a teaching session will occur smoothly?~~

~~C. What things can you do that would interfere with or disrupt a teaching session?~~

~~IX. History of the Undesirable Behavior(s) and Programs that Have Been Attempted~~

	~~Behavior~~	~~How long has this been a problem?~~	~~Programs~~	~~Effect~~
~~1.~~				
~~2.~~				
~~3.~~				
~~4.~~				

~~X. Summary/ Recommendations~~

~~Based on the Functional Behavior Assessment, the following action(s)/behavior(s) were discovered:~~

~~Behavior~~	~~Function~~	~~Location~~

~~The results of the assessment(s) reflect that the action(s)/behavior(s) demonstrated by the person pose a risk to the health and welfare of the person and/or others.~~	~~Yes~~	~~No~~

~~If a risk(s) exist, list them below:~~		
~~Behavior~~	~~Risk to Self~~	~~Risk to Others~~

~~**Recommendations:**~~

~~**Behavior Support Consultant/Credentials**~~ ~~**Date**~~

~~ID/DD Waiver Behavior Support Plan~~

~~Purpose~~

~~The Behavior Support Plan is developed by the Behavior Consultant based on the assessment(s) used to evaluate the person's actions or behavior(s).~~

~~General~~

~~All areas indicated on the Behavior Support Plan must be addressed:~~

- ~~Background information~~
- ~~Summary of the Functional Behavior Assessment~~
- ~~Tracking and reduction strategies~~
- ~~Objectives~~
- ~~Staff instructions for implementing the plan~~

~~Signatures~~

~~The following signatures must be obtained by the Behavior Support Consultant after completion and review of the Behavior Support Plan:~~

- ~~The parent/legal representative, if appropriate, and the person receiving services, indicating they agree with the contents of the Behavior Support Plan and consent for its implementation,~~

- ~~The Behavior Consultant agreeing to implement the plan as written and to notify the person/family/legal representative before making any changes or modifications,~~

- ~~The Behavior Support Specialist (when applicable) agreeing to implement the plan and collect data to report to the Behavior Support Consultant as indicated in the plan,~~

- ~~The Director or Supervisor of the program the person attends (if the Behavior Support Plan is to be implemented in such a setting), indicating he/she agrees with the content of the Behavior Support Plan and will provide support as necessary. Also, he/she is agreeing to allow appropriate staff to be trained by the Behavior Support Consultant and/or a Behavior Support Specialist to ensure the plan continues to be successful after the Consultant/Specialist has ceased providing services.~~

~~Timelines~~

~~The Behavior Support Plan must be completed within thirty (30) days of completion of the Functional Behavior Assessment.~~

~~A copy of the Behavior Support Plan, along with the Functional Behavior Assessment and Justification for Behavior Support Services, must be submitted to the Support Coordinator within ten (10) days of completion of the Behavior Support Plan. The Support Coordinator will submit the documentation to BIDD for review. The Behavior Support Plan must be approved before services can begin. The Behavior Support Plan must be reviewed at least quarterly.~~

~~A copy must be in the person's record no later than the 10th day of the month following the month it is approved by BIDD.~~

~~ID/DD Waiver Behavior Support Plan~~

~~Name:~~		**~~Behavior Consultant:~~**	
~~Medicaid #:~~		**~~Agency:~~**	
~~Address:~~		**~~Contact Number:~~**	
~~Phone Number:~~			

~~Background~~	
~~Reason for Referral:~~	
~~History:~~	
~~Psychiatric Diagnoses:~~	

~~Summary of Functional Behavior Assessment~~		
~~Target Identification Methods:~~		
~~Description of Assessment Procedures:~~		
~~Target Behavior(s) and Definitions:~~	~~Behavior(s)~~	~~Definitions~~

	~~Behavioral Description~~	~~Antecedents~~	~~Consequences~~
~~Behavioral Findings:~~			
~~Relevant Findings from Physiological Issues/Illness/Injury Assessment:~~			
~~Relevant Findings from Environmental and Setting Assessment:~~			
~~Relevant Findings from Communicative Functions:~~			
~~Hypothesis and Summary of Behavior Function(s):~~			
~~Baseline Data:~~			
~~Replacement Behaviors Identified:~~			

~~Tracking and Reduction~~

~~Behavior Reduction:~~	
~~Baseline Data:~~	
~~Intervention Expectation:~~	
~~Replacement/ Alternative Behavior:~~	
~~Review Criteria:~~	

~~Behavior Reduction:~~	
~~Baseline Data:~~	
~~Intervention Expectation:~~	
~~Replacement/ Alternative Behavior:~~	
~~Review Criteria:~~	

~~Behavior Reduction:~~	
~~Baseline Data:~~	
~~Intervention Expectation:~~	
~~Replacement/ Alternative Behavior:~~	
~~Review Criteria:~~	

~~**Objective(s)**~~	
~~1.~~	
~~2.~~	
~~3.~~	
~~4.~~	

~~**Staff Instructions**~~	
~~Preventive Measures:~~	
~~Replacement Behavior/Alternative Skill Training:~~	
~~Consequence Strategies:~~	
~~Procedural Safeguards:~~	
~~Medication Side Effects of Concern:~~	

~~**Agreements and Signatures**~~			
~~**I agree with the content of this Plan and give consent for its implementation. I have received a copy of the plan. I understand the behavior management techniques that will be used with this program. I may terminate the program at any time.**~~			
~~Person:~~		~~Date:~~	
~~Person/Legal Representative:~~		~~Date:~~	

~~**I agree to implement the Plan as described. If any modifications are necessary, I will contact the person/family before making any changes. I will ensure staff is trained before terminating my services.**~~			
~~Behavior Support Consultant:~~		~~Date:~~	
~~**I agree to the contents of this Plan and will support the Consultant/Interventionist as needed to ensure implementation of the Plan. Appropriate staff will receive training to ensure the Plan continues, as needed, after the Consultant/Interventionist terminates services.**~~			
~~Program Director:~~		~~Date:~~	

~~Behavior Consultant/Credential~~ ______________________ ~~Date:~~ ______________

~~**✥BIDD Use Only✥**~~	
~~**Approved**~~	~~**Denied**~~
~~**Signature of BIDD Staff**~~	~~**Signature of BIDD Staff**~~

~~ID/DD Waiver Justification for Behavior Support Services~~

~~Purpose~~

~~The provider uses the ID/DD Waiver Justification for Behavior Support Services to justify the type and amount of Behavior Support Services needed.~~

~~General~~

~~Based upon the Functional Behavior Assessment and Behavior Support Plan, indicate the amount of Behavior Support Services needed to change/modify targeted behaviors or whether or not only staff training is needed to change/modify targeted behaviors.~~

~~Timelines~~

~~The Justification for Behavior Support Services is submitted along with the Functional Behavior Assessment and Behavior Support Plan to the appropriate Support Coordinator within ten (10) days of initiation of the Behavior Support Plan. It must be maintained in the person's record. The SC then submits all documentation to BIDD for review.~~

~~ID/DD Waiver Justification for Behavior Support Services~~

~~**Name:**~~ ______________________ ~~**Medicaid Number:**~~ ______________

~~**Agency:**~~ ______________

~~Based upon the Functional Behavior Assessment completed~~ ____________ ~~it is recommended that Behavior Support services are warranted.~~ ~~(date)~~

~~It is anticipated that approximately~~ _________ ~~hours for~~ ______ ~~months will be required to implement the Behavior Support Plan.~~

~~OR~~

~~Based upon the Functional Behavior Assessment completed,~~ ____________ ~~it is recommended~~
~~(date)~~

~~that direct Behavior Support services are not warranted but there is a need for~~ ~~***staff training***~~

~~It is anticipated that approximately~~ _________ ~~hours will be required to adequately train staff to manage identified behaviors.~~

______________________________ ______________________________

~~**Behavior Support Consultant Signature/Credentials**~~ ~~**Date**~~

~~**BIDD Signature**~~ ~~**Date**~~

~~ID/DD Waiver Behavior Support Quarterly Review Report~~

~~Purpose~~

~~The Behavior Consultant must complete a Behavior Support Quarterly Review Report for each quarter services are provided. The report reflects the supports provided and the amount of progress made during that particular quarter.~~

~~General~~

~~Based on data gathered during each quarter, the Behavior Consultant composes a report that reflects medication changes, target behavior(s), information about Behavior Support Plan implementation, and narrative information about baseline data or data from the previous Quarterly Review Report as well as narrative information about the current quarter's data.~~

~~The report includes next steps to be taken in implementation of the Behavior Support Plan. Next steps could include actions such as continuing with the Behavior Support Plan as it is written or modifying it to meet any changing needs. Modifications can be made to the intervention, intervention techniques, target behaviors, training needs, timelines, etc.~~

~~The Behavior Support Quarterly Review Report must be signed and dated by the Behavior Consultant and be filed in the person's record by the 10th of every month. BIDD staff will review the Quarterly Reports onsite.~~

~~Timelines~~

~~The Quarterly Review Report is to be completed at the end of each three (3) months of service to the person. It is to be submitted to the Support Coordinator by the 15th of the month following the month it is completed.~~

~~ID/DD Waiver Behavior Support~~
~~Quarterly Review Report~~

~~Name:~~	**~~Date of Report:~~**
~~Medicaid Number:~~	
~~Behavior Consultant:~~	
~~Behavior Specialist:~~	
~~Support Coordinator:~~	
~~Behavior Support Plan Approved:~~	
~~Describe any changes in behavior, medication (include prescribing doctor) and/or diagnosis:~~	
~~Explain reasons for changes:~~	
~~Target Behaviors:~~	

~~Locations of Behavior Support Plan implementation:~~	~~Behavior Support Plan structure:~~
☐ ~~Home~~	☐ ~~Modeling~~
☐ ~~Day Program~~	☐ ~~Reinforcement/Consequences~~
☐ ~~Community~~	☐ ~~Training for staff/family~~
☐ ~~Place of Employment~~	☐ ~~One-on-one supervision~~
	☐ ~~Redirection & blocking~~
	☐ ~~Verbal Prompting~~
	☐ ~~Environmental accommodations~~
	☐ ~~Other:~~

~~Describe baseline data or data collected for previous review as well as a narrative of the previous review:~~

~~**ID/DD Waiver Behavior Support Quarterly Review Report**~~	
~~**Name:**~~	~~**Date of Report:**~~
~~**Medicaid Number:**~~	
~~Include a narrative of the current quarter's data.~~	
~~Next Steps:~~	

~~Behavior Consultant Signature /Credentials~~ ~~Date~~

~~ID/DD Waiver Request for Additional~~
~~Behavior Support Services~~

~~Purpose~~

~~When additional Behavior Support Services are deemed necessary by the Behavior Consultant, a Request for Additional Behavior Support Services form must be submitted to BIDD for approval.~~

~~General~~

~~The Behavior Consultant indicates the amount of service needed, the target behaviors, the number of Behavior Support service hours that have been used thus far, how they were used and includes justification for the additional hours being requested. The desired goal(s) or outcome(s) must be included.~~

~~The form and the most recent Quarterly Review Report are submitted to the appropriate Support Coordinator for submission to the BIDD for review.~~

~~ID/DD Waiver Request for~~ Additional
~~Behavior Support Services~~

~~(Use as many pages as necessary and attach most recent Quarterly Review Report)~~

~~Name:~~		**~~Date:~~**	
~~Medicaid #:~~		**~~Agency:~~**	
~~Behavior Consultant:~~		**~~Phone Number:~~**	
~~# Additional Hours Requested:~~		**~~# Hours utilized to date:~~**	

~~Target behavior(s):~~	
~~Justification for additional services:~~ **~~(why hours are needed and how they will be used)~~**	
~~Desired goals/outcomes:~~	

~~❖BIDD USE ONLY❖~~	
~~Approved~~	**~~Disapproved~~**

~~ID/DD Waiver Request for~~ ~~Additional~~
~~Crisis Support Services~~

~~Purpose~~
~~Crisis Support Services can be provided for up to thirty (30) days per a person's certification year. If additional Crisis Support Services are deemed necessary by the Program Supervisor, a Request for Additional Crisis Services form must be submitted for approval.~~

~~General~~
~~The Program Supervisor indicates the additional number of days needed, the targeted behaviors, the number of days that have been used thus far, how they were used and includes justification for the additional days being requested. The desired goal(s) or outcome(s) must be included.~~

~~The form and any attached documentation are submitted to the appropriate Support Coordinator for submission to the BIDD for review. The maximum number of days of Crisis Support someone may receive without additional approval is thirty (30).~~

~~ID/DD Waiver Request for Additional Crisis Support Services~~

~~(use as many pages as necessary)~~

~~Name:~~		~~Date:~~	
~~Medicaid #:~~		~~Regional Program:~~	
~~Program Supervisor:~~		~~Phone Number:~~	
~~Additional # Days Requested:~~		~~# Days utilized to date:~~	

~~Targeted behavior(s):~~	
~~Justification for additional services:~~ ~~(why days are needed and how they will be used)~~	
~~Desired goals/outcomes:~~	

~~❖BIDD ONLY❖~~	
~~Approved~~	~~Disapproved~~

~~Request for ID/DD Waiver~~
~~Crisis Intervention Services~~

~~Purpose~~

~~The form must be completed when a person requests ID/DD Waiver Crisis Intervention services.~~

~~General~~

~~Crisis Intervention Services are approved on an individual's Plan of Services and Supports when there is a reasonable expectation, based on past occurrences or immediate situational circumstances in which the individual is at risk of causing physical harm to him/herself, causing physical harm to others, damaging property, eloping, or being unable to control him/herself in a manner that allows participation in usual activities of daily life. The provider will be chosen at the time the service is approved on the Plan of Services and Supports; therefore, if a crisis arises, the provider can be dispatched immediately.~~

~~If a need for Crisis Intervention arises whereby a provider must provide immediate assistance, but the service is not yet on the Plan of Services and Supports, the provider and Support Coordinator must work together to gather justification for the need for the service and submit this form to BIDD for review. The request must be submitted to BIDD within five (5) days of the initiation of Crisis Intervention services.~~

~~Crisis Intervention can be requested for up to seven (7) days or 168 hours. If additional services are deemed to be necessary, the provider must submit the ID/DD Waiver Request for Additional Crisis Intervention Services from to the Support Coordinator who will then submit it to BIDD for review.~~

~~The ID/DD Waiver Crisis Intervention Services provider notifies the Support Coordinator that services have been utilized. The provider completes the form. It must be signed by the Clinical Supervisor of the ID/DD Waiver Crisis Intervention Services Team.~~

~~Timelines~~

~~If a person receives Crisis Intervention services prior to the service being approved on their Plan of Services and Supports, the Support Coordinator has five (5) days from the date services were provided to work with the provider to get the form completed and submit it to BIDD for approval.~~

~~ID/DD Waiver Request for Crisis Intervention Services~~

~~Name:~~		~~Date of Request:~~	
~~Medicaid Number:~~		~~Regional Program:~~	
~~Support Coordinator:~~		~~Phone Number:~~	
~~# of Days/Hours Being Requested:~~			
~~Diagnoses:~~			
~~Current Medications:~~			
~~Target Behavior(s):~~			
~~Frequency of behavior(s):~~		~~Date of last occurrence of behavior(s):~~	
~~Environment(s) where behavior(s) occur(red):~~			
~~Desired goal/outcome of service:~~			
~~Has the person received the service(s) before?~~		☐ ~~Yes~~	☐ ~~No~~
~~If so, list dates, provider(s), outcomes/goals achieved and why service ended:~~			
~~Source(s) of Information:~~			

~~Clinical Supervisor/Credentials~~

~~Date~~

~~❖BIDD ONLY❖~~	
~~Approved~~	~~Disapproved~~

~~ID/DD Waiver~~
~~Crisis Intervention Plan~~

~~Purpose~~
~~The ID/DD Waiver Crisis Intervention Plan is developed for people who utilize IDD Waiver Crisis Intervention Services.~~

~~General~~
~~A Crisis Intervention Plan is developed for someone for whom the service is on his/her approved Plan of Care and staff/family know his/her potential crisis(es), as well as for those people who have experienced a crisis and received ID/DD Waiver Crisis Intervention Services. The person can either have received the service on an episodic basis or it can be for someone who requires the service on a 24/7 basis, depending on the nature of the crisis and the person's individual circumstances.~~

~~The ID/DD Waiver Crisis Intervention Plan is used to provide a plan for use in mitigating and intervening in a person's individual crisis situation. There can be multiple types of crises addressed on a single plan. Describe the person's relevant history in regard to the presenting crisis(es) and the known trigger(s) for said crisis(es). The ID/DD Waiver Crisis Intervention Team and the person/legal representative, Support Coordinator and providers, if applicable, then work to develop the ID/DD Waiver Crisis Intervention Plan that can be implemented in the home, the community, a day program or some combination of sites.~~

~~In addition to the case record, copies of the ID/DD Waiver Crisis Intervention Plan are to be maintained in all settings where it may be implemented and the ID/DD Waiver Crisis Intervention Team is to train all individuals who may have to implement components of the ID/DD Waiver Crisis Intervention Plan.~~

~~The ID/DD Waiver Crisis Intervention Team also provides a Team member's name and phone number to contact in case of a crisis which cannot be resolved by implementing the ID/DD Waiver Crisis Intervention Plan.~~

~~It is signed by the person/legal representative, the ID/DD Waiver Crisis Intervention Team Clinical Supervisor, by ID/DD Waiver Crisis Team staff who is primarily responsible for implementation, if applicable, a staff of another provider(s) who may have to implement the plan as well other ID/DD Waiver Crisis Intervention Team staff who may have to implement the ID/DD Waiver Crisis Intervention Plan.~~

~~Timelines~~
~~The ID/DD Waiver Crisis Intervention Plan must be developed within five (5) days of the provision of or referral for ID/DD Waiver Crisis Intervention Services.~~

~~Copies of the ID/DD Waiver Crisis Intervention Plan must be sent to all applicable parties no more than five (5) days following development. It must be in the person's record no later than the 10th of the month following the month it is developed. The Crisis Intervention Plan must be submitted to the Support Coordinator by the 15th of the month following the month it is developed.~~

~~ID/DD Waiver Crisis Intervention Plan~~	**~~Name:~~** ______ **~~Medicaid Number:~~** ______ **~~Provider Agency:~~**

~~Crisis Intervention Team Contact:~~	~~Phone number:~~
~~Relevant History and Potential Crisis Situation(s):~~	~~Current Medications~~
~~Known Triggers:~~	

~~Action Steps for Home~~	~~Action Steps for Community Locations (specify location(s))~~	~~Action Steps for Day Programs~~
~~Person/Legal Guardian Signature/Date~~	~~Crisis Intervention Team Clinical Supervisor Signature/Credentials/Date~~	~~Responsible Crisis Intervention Team Staff Signature/Credentials/Date~~
~~Other Provider Signature/Credentials/Date~~	~~Other Responsible Crisis Intervention Team Staff Signature/Credentials/Date~~	~~Other Responsible Crisis Intervention Team Staff Signature/Credentials/Date~~

~~ID/DD Waiver~~
~~Crisis Intervention Daily Service Note~~

~~Purpose~~
~~This form is used during the provision 24/7 daily ID/DD Waiver Crisis Intervention Services.~~

~~General~~
~~The ID/DD Waiver Crisis Intervention Daily Service Note must include analysis of the behaviors and contributing factors, progress in implementing the ID/DD Waiver Crisis Intervention Plan, providing direct supervision or support, counseling and training family members and/or staff how to remediate the current crisis and prevent its reoccurrence.~~

~~The form is designed to be a running document that allows staff to document activities/events that take place during the provision of ID/DD Waiver Crisis Intervention Services on a 24/7 basis. The time services begin as well as when they end must be documented. Use a.m./p.m. Notes should run from the time the service actually begins on any given day until 11:59 p.m. Notes for the next day begin at 12:00 a.m. and end on the day and time the person leaves the service. There must be notes from all shifts detailing the person's activities (meal times, leisure activities, personal hygiene activities, attendance at a day program, etc.) as well as reactions to implementation of the ID/DD Waiver Crisis Intervention Plan.~~

~~Timelines~~
~~ID/DD Waiver Crisis Intervention Daily Service Notes must be in the person's record no later than the 10th of the month following the month they were completed.~~

~~ID/DD Waiver Crisis Intervention Daily Service Note~~	~~Name~~ ____ ~~Agency~~ ____ ~~Medicaid #:~~ ____ ~~Page~~ ~~of~~

~~Staff Signature/Credentials~~	~~Date (m/d/yr)~~	~~Time In (am/pm)~~	~~Time Out (am/pm)~~	~~Total Time~~

~~Notes~~

~~ID/DD Waiver Crisis Intervention Log - Episodic~~

~~Purpose~~

~~The ID/DD Waiver Crisis Intervention Log – Episodic is used to document the provision of ID/DD Waiver Crisis Intervention Services as they occur episodically, not in the provision of 24/7 ID/DD Waiver Crisis Intervention Services.~~

~~General~~

~~Document the name, Medicaid number, time services began, time services ended, and the total amount of time in service provision. The location(s) where services are provided must be listed. This could be in the person's home, in a community location, at a program site or a combination of more than one (1) site. List the names of the people involved in the situation and their relationship to the person. If someone else receiving services is involved, simply list his/her relationship to the person. For example, list "another person participating in the program" rather than Bob Smith.~~

~~Describe in detail the nature of the situation which required ID/DD Waiver Crisis Intervention services. This could include elopement, damage to property, self, others, etc. This is the justification for the provision of services.~~

~~Describe in detail the action(s) taken to address the situation before the arrival of Crisis Intervention staff. This includes information about what staff/family/others did to intervene in or mitigate the crisis.~~

~~Describe action(s) taken by Crisis Intervention staff to resolve the crisis. This could include counseling, the use of Mandt© techniques, removal from the situation to another setting, etc.~~

~~Describe in detail the final resolution of the crisis. Indicate the person's condition at the end of the crisis. Part of the resolution of the crisis may be that the person is removed from the setting for an extended period of time that may cover one or more days. Also document if referrals were made to other agencies, which agencies, the reason for referral and the appointment time, if applicable.~~

~~Indicate if the ID/DD Waiver Crisis Intervention Plan was implemented as written or if, as a result of the current situation, it requires revision. If this is the first time services have been provided, the ID/DD Waiver Crisis Intervention Plan must be developed within five (5) days.~~

~~The staff who provided ID/DD Waiver Crisis Intervention Services sign and date the form upon completion. Even though there is only one line for staff signature/credentials, if more than one (1) staff participated in the event, include their signature and credentials also.~~

~~Timelines~~

~~The ID/DD Waiver Crisis Intervention Log – Episodic must be completed each time services are~~

~~provided. If it is the first time services are being provided, the Clinical Supervisor must notify the person's ID/DD Waiver Support Coordinator to request from BIDD that it be added to the person's ID/DD Waiver Plan of Care/Plan of Services and Supports within five (5) days of the provision of ID/DD Waiver Crisis Intervention Services. The justification for the need for services is documented on the ID/DD Waiver Request for Crisis Intervention Services form. The provider completes the ID/DD Waiver Request for Crisis Intervention Services form and submits it to the Support Coordinator who will then submit it to BIDD for review by the Behavior Services Oversight Team.~~

~~All ID/DD Waiver Crisis Intervention Logs must be in the person's record no later than the 10th of the month following the month they are completed.~~

~~ID/DD Waiver Crisis Intervention Log~~ ~~(Episodic)~~	~~Name:~~			
	~~Medicaid Number:~~			
	~~Date~~	~~Time Began~~	~~Time Ended~~	~~Total Time~~

~~Location(s) where services provided:~~

~~People Involved and Relationship:~~

~~Situation Requiring Support~~

~~(Use as much space as needed)~~

~~Action(s) Prior to Crisis Intervention Staff Arrival~~

~~(Use as much space as needed)~~

~~Action(s) of Crisis Intervention Staff~~

~~(Use as much space as needed)~~

~~Resolution~~

~~(Use as much space as needed)~~

~~Crisis Plan Implemented ☐~~ ~~Crisis Plan Requires Revision ☐~~ ~~Crisis Plan Needed ☐~~

~~Staff Signature/Credentials~~ ~~Date~~

~~Clinical Supervisor Signature/Credentials~~ ~~Date~~

~~ID/DD Waiver Request for Additional Crisis Intervention Services~~

~~Purpose~~
~~When additional Crisis Intervention Services are deemed necessary by the Program Supervisor, a Request for Additional Crisis Intervention Services form must be completed.~~

~~General~~
~~The Program Supervisor indicates the additional number of days/hours needed, the targeted behaviors, the number of days/hours that have been used thus far, how they were used and includes justification for the additional days/hours being requested. The desired goal(s) or outcome(s) must be included.~~

~~Timelines~~
~~The form and any attached documentation are submitted to the appropriate Support Coordinator for submission to the BIDD for review. The maximum number of hours of Crisis Intervention someone may receive without additional approval is 168 hours.~~

~~ID/DD Waiver Request for Additional Crisis Intervention Services~~

~~Name:~~		~~Date:~~	
~~Medicaid #:~~		~~Agency:~~	
~~Behavior Consultant:~~		~~Phone Number:~~	

~~# Additional hours requested:~~		~~OR~~	~~# Additional days requested~~	
~~# Hours utilized to date:~~			~~# Additional Days utilized to date:~~	

~~Target behavior(s):~~	
~~Justification for additional services:~~ ~~(why hours/days are needed and how they will be used)~~	
~~Desired goals/outcomes:~~	

~~❖BIDD USE ONLY❖~~	
~~Approved~~	~~Disapproved~~

~~Section J~~
~~Substance Use Disorder Services~~

~~Educational Activities/Risk Assessments for TB/HIV/STD~~

~~Substance Abuse Monthly Capacity Management and Waiting List Report~~

~~Emergency Placement for Pregnant Women~~

~~Emergency Placement for IV Drug Users~~

~~Risk Assessment Interview & Educational Activities for TB/HIV/STDs~~

~~Purpose~~

~~All individuals receiving substance use treatment services (i.e., Outpatient/Intensive Outpatient Services, Primary/Transitional Residential Services, Withdrawal Management Services, Opioid Treatment Services, Recovery Support Services, DUI Diagnostic Assessment Services) must receive a TB and HIV Risk Assessment Interview as well as educational information on HIV/AIDS, TB, STDs, and Hepatitis.~~

~~Applicability~~

~~Under each section, if any of the items do not apply, document as "not applicable."~~

~~Risk Assessment Interview for TB/HIV/STDs Form~~

~~The staff should verbally administer the interview questions and mark the individual's responses on the Risk Assessment Interview Form. Staff should indicate any additional information in the comments section. After completion on the Assessment Interview, Staff should sign with credentials and date the form.~~

~~Educational Activities & Risk Assessments for TB/HIV/STDs Form~~

~~Educational Activities~~

~~Lines 1-4: Record the month/day/year and total amount of time spent on each education topic. A minimum of one hour of HIV Prevention Education is required for all individuals in treatment at funded Substance Abuse Block Grant HIV Early Intervention Services programs (SABG HIV-EIS). Educational activities can be conducted in group and/or individual sessions.~~

~~HIV Risk Assessment, Testing, & Counseling~~

~~Line 1~~ ~~Record month/day/ year that the Risk Assessment Interview was completed for the individual receiving substance use treatment services. Total Time is not applicable for Line 1 item.~~

~~Line 2~~ ~~Record the month/day/year and total time that the individual received HIV pre-test counseling. This is applicable to all individuals receiving treatment services, even if they opt out of HIV testing. For SABG HIV-EIS, a minimum of 30 minutes pre-testing counseling is required.~~

~~Line 3~~ ~~Record YES if the individual received HIV testing and the month/day/year the individual was tested. Record NO if the individual receiving services opts-out of testing. An Opt-Out form must be completed if NO is marked. Indicate the month/day/year the Opt-Out form was completed and signed by the individual. Total Time is not applicable for Line 3 items.~~

~~Line 4~~ ~~Record the month/day/year and total time the individual receiving services was provided post-test counseling. Post-test counseling can only be provided IF testing was conducted. For SABG HIV-EIS, a minimum of 30 minutes of post-test counseling is required, with 60 minutes for a reactive HIV test.~~

~~Tuberculosis Risk Assessment, Testing, & Referral~~

~~Line 1 Record the month/day/year the Risk Assessment Interview was completed for the individual receiving primary substance use treatment services.~~
~~Check YES if results indicate further action is needed.~~
~~Check NO if results of risk assessment do not indicate that further action is warranted.~~
~~If an individual is determined to be high risk, the individual cannot be admitted to treatment until testing confirms the individual does not have TB.~~

~~Line 2 If further testing is not required, document as "not applicable."~~
~~If Skin Test is completed, record month/day/year when the skin test was administered to the individual.~~
~~Check YES if further action will be taken after the skin test.~~
~~Check NO if results of skin test indicate that no further action appears warranted.~~

~~Line 3 If further testing is not required, document as "not applicable."~~
~~If X-ray testing is required, record month/day/year that individual received an X-ray to determine their TB status.~~
~~Check YES if further action will be taken after the X-ray.~~
~~Check NO if results of X-ray indicate that no further action appears warranted.~~

~~Line 4 If further treatment is not required, document as "not applicable."~~
~~If TB treatment is required, record month/day/year when the individual was referred for treatment for tuberculosis.~~

~~Individual Receiving Services Signature/Date~~

After ~~receiving all applicable risk assessments/educational activities, the individual receiving substance use treatment services must sign and date the form where indicated.~~

~~Staff Signature/Credentials/Date~~

After ~~the individual has received all applicable risk assessments/educational activities, the staff person responsible for verifying the administration of these risk assessments/educational activities must sign, date, and record their credentials.~~

~~Risk Assessment Interview for TB/HIV/STDs~~

~~Name~~ ______________________

~~ID Number~~ ______________________

~~Date~~

~~1.~~	~~Have you ever tested positive, been diagnosed with, or treated for tuberculosis (TB)?~~	~~❑Yes~~	~~❑No~~
~~2.~~	~~Has anybody you know or have lived with been diagnosed with or tested positive for TB in the past year?~~	~~❑Yes~~	~~❑No~~
~~3.~~	~~a. Within the last month, have you had any of the following symptoms lasting for more than 2 weeks? If yes, please check items below.~~		~~❑No~~
	~~❑ Fever~~ ~~❑ Drenching night sweats~~ ~~❑ Coughing up blood~~		
	~~❑ Losing weight~~ ~~❑ Shortness of breath~~ ~~❑ Lumps or swollen glands~~		
	~~❑ Diarrhea lasting more than one week~~		
	~~b. Are you now living with someone with any of the following?~~		~~❑No~~
	~~❑ Coughing up blood~~ ~~❑ Drenching night sweats~~ ~~❑ Active TB~~		
~~4.~~	~~Have you ever been told that you have a positive HIV test? (test for the AIDS virus)~~	~~❑Yes~~	~~❑No~~
~~5.~~	~~Do you have a history of IV drug usage?~~	~~❑Yes~~	~~❑No~~
~~6.~~	~~Have you used cocaine (I.E., powder, crack...etc.)?~~	~~❑Yes~~	~~❑No~~
~~7.~~	~~Have you ever engaged in unprotected vaginal, anal or oral sex with multiple partners and/or anonymous partners?~~	~~❑Yes~~	~~❑No~~
~~8.~~	~~Have any of your current or previous sex partners used IV drugs or been HIV positive?~~	~~❑Yes~~	~~❑No~~
~~9.~~	~~Have you ever been paid to have sex or to exchange sex for food, shelter, etc.?~~	~~❑Yes~~	~~❑No~~
~~10.~~	~~Have you ever been the victim of sexual assault?~~	~~❑Yes~~	~~❑No~~
~~11.~~	~~Have you ever used alcohol or drug before or during sex?~~	~~❑Yes~~	~~❑No~~
~~12.~~	~~Have you been diagnosed with or treated for hepatitis and/or a sexually transmitted disease?~~	~~❑Yes~~	~~❑No~~
~~13.~~	~~Have you ever lived on the street or in a shelter?~~	~~❑Yes~~	~~❑No~~
~~14.~~	~~Have you ever been incarcerated or in jail?~~	~~❑Yes~~	~~❑No~~
~~15.~~	~~Have you had a blood transfusion prior to 1992?~~	~~❑Yes~~	~~❑No~~
~~16.~~	~~Were you born between the years 1945 and 1965?~~	~~❑Yes~~	~~❑No~~

~~Comments:~~

______________________ ______________________

~~Staff Signature/Credentials~~ ~~Date~~

~~Educational Activities & Risk Assessments for TB/HIV/STDs~~

~~Name~~	
~~ID Number~~	

~~Educational Activities~~	**~~Date Completed~~**	**~~Total Time~~**
~~1. HIV/AIDS Information (minimum of 1 hour required for funded SABG HIV-EIS programs)~~ ~~(including modes of transmission, universal precautions and other preventative measures, current treatments and how to access them)~~		
~~2. Sexually Transmitted Diseases (STDs)~~ ~~(including modes of transmission, precautions to take against contraction, progression of diseases, current treatment resources and how to access them)~~		
~~3. Tuberculosis~~ ~~(including modes of transmission, current treatment resources and how to access them)~~		
~~4. Hepatitis~~ ~~(including modes of transmission, precautions to take against contraction, current treatments and how to access them)~~		

~~HIV Risk Assessment, Testing, & Counseling~~			**~~Date Completed~~**	**~~Total Time~~**
~~1. Completion of Risk Assessment Interview~~				
~~2. Provided HIV Pre-Test Counseling (minimum of 30 minutes)~~				
~~3. Provided HIV Testing~~				
	~~❑ Yes~~			
	~~❑ No~~	~~❑ Opt-out form completed for refusal of testing on:~~		
~~4. Provided Post-Test Counseling if testing was conducted (minimum of 30 minutes; 60 minutes for a reactive HIV test)~~				

~~Tuberculosis Risk Assessment, Testing, & Referral~~	**~~Date Completed~~**
~~1. Completion of Tuberculosis Risk Assessment~~	
~~Do results indicate further action? ❑ Yes ❑ No~~	
~~2. Completion of Skin Test~~	
~~Do results indicate further action? ❑ Yes ❑ No~~	
~~3. Completion of X-ray~~	
~~Do results indicate further action? ❑ Yes ❑ No~~	
~~4. Referred for Tuberculosis Treatment~~	

~~By signing, you acknowledge receipt of the educational information and all risk assessments listed above.~~

~~Individual Receiving Services~~	**~~Date~~**	**~~Staff Signature/Credentials~~**	**~~Date~~**

~~Substance Abuse Monthly Capacity Management and Waiting List Reports~~

~~Purpose~~

~~All substance abuse programs must give first priority to the acceptance and treatment of pregnant women. Substance abuse programs must also provide treatment to IV drug users. Written documentation of placement or assessment and referral of pregnant women and IV drug users must be maintained and reported to the DMH.~~

~~Timeline~~

~~To assist with appropriate referrals and placement, all residential programs must report to DMH when the census of the program exceeds 90% capacity and when the census drops below 90% capacity. Report should be submitted to the Office of Consumer Support by fax within 24 hours of crossing the 90% threshold.~~

~~Pregnant women must be admitted to a program for treatment within forty-eight (48) hours of an initial contact. IV drug users must be placed in substance abuse treatment programs within forty-eight (48) hours of an initial contact. Reports must be submitted to the Office of Consumer Support by fax by the 10th working day of the month following the reporting period.~~

~~The program must monitor and complete the process of securing the most appropriate program for pregnant women and IV drug users. If the most appropriate program has not been secured by the end of a reporting month, the report must be sent to the Office of Consumer Support by fax indicating where the individual is in the process. The program must continue to submit the information on the individual each month until he/she is admitted into the appropriate program.~~

~~**Substance Abuse Capacity Management**~~ ~~**Timeline within 24 hours**~~	~~**Facility Name**~~ ______________________ ~~**Date**~~ ______________________

☐ ~~At 90% capacity~~

☐ ~~No longer at 90% capacity~~

~~**Fax or Email to:**~~

~~Office of Consumer Support~~

~~Fax Number: (601)359-9570~~

~~Emergency Placement for Pregnant Women~~ **~~Timeline: within 48 hours of initial contact~~**	**~~Date~~** ______________ **~~Time of Contact~~** ______________ **~~Type of Contact~~** ______________ **~~Facility Name~~** ______________

~~Client Information~~	
~~Name~~	
~~Address~~	
~~Telephone Number~~	
~~Other Contact Information~~	

~~Fax or Email:~~
~~Office of Consumer Support~~
~~Fax Number: (601)359-9570~~

____
~~Date Submitted to DMH~~

# ~~Emergency Placement for IV Drug Users~~ **~~Timeline: within 48 hours of initial contact~~**	**~~Date~~** __________ **~~Time of Contact~~** __________ **~~Type of Contact~~** __________ **~~Facility Name~~** __________

~~Client Information~~	
~~Name~~	
~~Address~~	
~~Telephone Number~~	
~~Other Contact Information~~	

~~Fax or Email:~~
~~Office of Consumer Support~~
~~Fax Number: (601)359-9570~~

____
~~Date Submitted to DMH~~

~~Section K~~
~~Administrative Information~~

~~Disaster Preparedness and Response Guidance~~

~~Disaster, Fire, and COOP Drills for all Programs~~

~~DMH Plan of Compliance Template~~

~~Staff Verification of Training on Abuse or Neglect Reporting Requirements~~

~~DISASTER PREPAREDNESS AND RESPONSE~~
~~Guidance for Operational Standards~~

~~This document contains guidance to assist your program with compliance with The Mississippi Department of Mental Health Operational Standards for Disaster Preparedness and Response as well as the Continuity of Operations Plan (COOP). By using this guidance, you will be more likely to meet the required elements for each standard listed. This guidance is not meant to be copied and pasted into your Policy and Procedures Manual, but is simply a guide to assist you in meeting the agency's standards.~~

~~Beneath each standard (**in bold**) you will find guidance that will assist you in meeting the desired outcome of that standard. Some of the standards require completion of certain tasks. For example, in the introduction to the emergency/disaster response plan section you must have a plan for each site that is "reviewed by the governing body". You must have in your plan a statement that the plan will be reviewed by the governing body, how often, and how you will document this.~~

~~If you have specific questions regarding these standards, please contact The Mississippi Department of Mental Health, Office of Incident Management at 601-359-6652 or send email questions to randy.foster@dmh.ms.gov.~~

~~**Rule 13.9.A Providers must develop and maintain an emergency/disaster response plan for each service location/site, approved by the governing body, for responding to natural disasters, manmade disasters (fires, bomb threats, utility failures and other threatening situations, such as workplace violence). The plan should identify which events are most likely to affect the location/site. For example, the location/site is located near an airport, railroad, nuclear power plant, typical path of tornado, earthquake zone, coastal region, etc. This plan must address at a minimum:**~~

- ~~You must have a plan for each service location/site. Each plan may have many of the same elements as other sites, but each site is a little bit different and the plan should reflect those differences.~~
- ~~This plan must be approved by your governing authority; you must have documentation of this in meeting minutes.~~
- ~~Each program should have as a part of the plan a response for each type of identified threat~~
    - ~~Natural events such as tornado, hurricane, wild fire, etc.~~
    - ~~Man-made events such as bomb threats, work place violence, etc.~~

~~To accurately assess the hazards that each location/site might be vulnerable to, it is suggested that you complete a Hazard Vulnerability Analysis (HVA) or contact the county to obtain county level HVA info. Please see attachment A for more information on how to conduct a HVA.~~

1. ~~**Lines of authority and Incident Command**~~

~~Identify who will be in charge for the whole agency and for each location/site in the event of an emergency/disaster. An organizational chart would be helpful here in the event that the identified person is not available.~~

2. ~~**Identification of a Disaster Coordinator**~~

~~Please designate one person that will act as your Disaster Coordinator. This individual will be in charge of making sure the plan is accurate and up to date, drills are conducted appropriately, and that the agency and each location are prepared to respond.~~

3. ~~**Notification and plan activation**~~

~~This section must contain what triggers activation of the plan, who officially activates the plan, and once the plan has been activated how staff and individuals who receive services are notified of the event. Part of this section should be notification to DMH, and local emergency personnel that need to be notified based on the nature of the event (Fire, Police, DEQ, Emergency Management, etc.).~~

4. ~~**Coordination of planning and response activities with local and state emergency management authorities**~~

~~Your agency and programs must coordinate with the local emergency response agencies. Typically, these are the local Fire Department, local Police Department, and local Emergency Management Agency. There may be other response agencies, such as non-profit agencies or other state/local agencies, which you may benefit from coordinating with as well. Each of these agencies may benefit from having a copy of your emergency/disaster response plan for review, comment and reference.~~

~~5. Assurances that staff will be available to respond during an emergency/disaster~~

~~You must have sufficient staff to continue the essential functions of the agency. You should identify how you will ensure that the needed staff is available to handle those responsibilities. This section should also address how your agency will ensure that staff is available to respond to community needs during an event.~~

~~6. Communication with individuals receiving services, staff, governing authorities, and accrediting and/or licensing entities~~

~~Outline how you will notify individuals receiving services, staff, your governing authorities, and your accrediting and/or certifying entities that an event has occurred, your plan has been activated, and to what extent and for how long your services will be affected.~~

~~7. Accounting for all persons involved (staff and individuals receiving services)~~

~~When the event occurs and directly affects your program, outline how you will make sure all of those present at the time of the event, both staff and individuals receiving services, are safe and accounted for. This could be done with attendance logs, lists of those staff that may be traveling, or other means of accounting for everyone. There must be a method to account for each individual.~~

~~8. Conditions for evacuation~~

~~Outline conditions that would cause you to evacuate your facility. A fire would be an example, but there are others as well such as power failure, sewage and/or water failure, foreseen unsafe conditions (hurricane, etc.), gas leaks (must comply with EMA directives regarding evacuation for gas leaks) and others. You should address all of those here.~~

~~9. Procedures for evacuation~~

~~Outline procedures for evacuation. Here you should identify the different types of evacuation as well. For example, the evacuation of your location for a fire is a different type of evacuation than leaving the location and area due to weather or chemical exposure. This section should also address the plan if the decision is made to shelter in place.~~

~~10. Conditions for agency closure~~

~~Under what conditions would your agency close? Some reasons might include damage to the facility, prolonged utility outage, infrastructure failure, and others.~~

~~11. Procedures for agency closure~~

~~If the conditions have been met for agency closure, what is the procedure? Who has the authority to order the agency closure? Who will be responsible for notification procedures?~~

~~12. Schedules of drills for the plan~~

~~Drills are required to be held on a schedule to ensure that staff is prepared in the event of an actual emergency/disaster. This schedule is the minimum requirement; more drills should be conducted if they are deemed necessary. The minimum schedule of drills should be as follows:~~

~~Quarterly fire drills for day programs~~

~~Monthly fire drills for residential programs, conducted on a rotating schedule within the following time frames:~~

~~7 a.m. to 3 p.m.~~
~~3 p.m. to 11 p.m.~~
~~11 p.m. to 7 a.m.~~

~~Quarterly disaster drills, rotating the nature of the event for the drill based on the emergency/disaster plan, for each facility and program.~~

~~Annual drill of Continuity of Operations Plan for the agency.~~

~~Drills should be unannounced as much as possible to ensure they are as real as possible.~~

13. **~~The location of all fire extinguishing equipment, carbon monoxide detectors (if gas or any other means of carbon monoxide emission is used in facility) and alarms/smoke detectors~~**

~~In your plan you should have a map that shows the location of these items or a written description of the location of these items. The physical presence of these items in these locations will be checked on site visit.~~

14. **~~The identified or established method of annual fire equipment inspection~~**

~~All fire equipment must be inspected on a set schedule, usually annually and by a professional from either the Fire Department or the equipment company. The method of inspection and documentation of inspection must be outlined here.~~

15. **~~Escape routes and procedures that are specific to location/site and the type of disaster(s) for which they apply.~~**

~~A copy of the escape routes must be in the emergency/disaster response plan for reference. These signs should be posted in visible locations, oriented to the location in the building, with a route for evacuation specific to that location.~~

~~CONTINUITY OF OPERATIONS PLAN REVIEW~~

~~*Understand that this Continuity of Operations Plan (COOP) is for the agency as a whole, not for specific sites/locations. Only 1 COOP is required for the agency. Each site should be provided a copy of the agency's COOP.~~

~~Rule 13.9.B Providers must develop and maintain a Continuity of Operations Plan, approved by the governing body, for responding to natural disasters, manmade disasters, fires, bomb threats, utility failures and other threatening situations, such as workplace violence. This plan must address at a minimum:~~

~~The following standards address your Continuity of Operations Plan (COOP). This plan is in place in the event that an emergency/disaster occurs. This plan ensures that essential functions can continue no matter what type of event occurs. Your governing body should approve this plan and any changes to it. Please note that the following standards are the minimum this plan should address.~~

1. **~~Identification of provider's essential functions in the event of emergency/ disaster~~**

~~What are the essential functions of your agency? These are functions that your program's clients would need even during an emergency/disaster. Some examples could be medications, individual therapies, residential treatment, or any other number of services.~~

2. **~~Identification of necessary staffing to carry out essential functions~~**

~~List the staff members (not specific names, but positions) that your agency will need to ensure that the essential functions will continue. List the capacity in which these individuals will serve and backup staff if these individuals are not available.~~

3. **~~Delegations of authority~~**

~~Who has the authority to assign tasks and duties? A COOP organizational chart that shows minimal staff and responsibilities in the event that the COOP Plan is activated, might be useful here.~~

4. **~~Alternate work sites in the event of location/site closure~~**

~~You have identified essential functions and you must identify an alternate location for those functions to continue if your location/site is not able to provide those functions. These sites must be identified and named with memorandum of agreements (MOA) or understanding (MOU) in place with the location if needed. It is not sufficient to simply state that you will find a location if needed at the time of the event.~~

~~5. Identification of vital records and their locations~~

~~If you have vital records for staff or individuals served, those are to be identified here along with the location of those records. Vital records may include case record, personnel records and financial records for agency. This does not have to include all records, but should include any records essential to continuing operations.~~

~~6. Identification of systems to maintain security of and access to vital records.~~

~~How will you maintain the security of these vital records during the event? Buildings may be compromised, the records may need to be transported to other locations, and the security and confidentiality of those records is important and must be addressed here. How are your records backed-up and how often does this back-up occur?~~

~~Rule 13.9.C Copies of the Emergency/Disaster Response Plans and the Continuity of Operations Plan must be maintained on-site for each location/site and at the agency's administrative offices.~~

~~You must have copies on site of both the Emergency/Disaster Response Plans and the Continuity of Operations Plan at each location/site. This ensures that in any event, the staff at every location have access to the needed materials to follow these plans. These will be checked during the site visit for each program.~~

~~Rule 13.9.D Any revisions to the Emergency/Disaster Response Plans and the Continuity of Operations Plan must be documented and approved by the agency's governing body. Any revisions must be communicated in writing to all staff.~~

~~Any changes to either plan must be reviewed and approved by the governing body and evidence of this must be documented in the meeting minutes. You should note in the plan itself that these plans will be reviewed by your governing body. These minutes will be reviewed by the site visit team. All staff must be notified of any changes to these plans.~~

~~Rule 13.9.E All locations/sites must document, utilizing the standardized DMH form, implementation of the written plans for emergency/disaster response and continuity of operations. This documentation of implementation must include, but is not limited to the following:~~

~~1. Quarterly fire drills for day programs~~

~~For day programs, you must conduct a fire drill in each of the four quarters of the year:~~
~~Jan-Mar, Apr-Jun, Jul-Sept, and Oct-Dec.~~

~~2. Monthly fire drills for residential programs, conducted on a rotating schedule within the following time frames:~~

~~7 a.m. to 3 p.m.~~
~~3 p.m. to 11 p.m.~~
~~11 p.m. to 7 a.m.~~

~~For residential programs, you must conduct a monthly fire drill rotating between the timeframes listed. For example: Jan – 7A-7P, Feb 3P-11P, Mar 11P-7A.~~

~~This schedule would meet the minimum requirements of each shift participating in one drill each quarter. It may be beneficial for each shift to have a drill each month, but it is not required.~~

~~3. Quarterly disaster drills, rotating the nature of the event for the drill based on the emergency/disaster plan, for each facility and program.~~

~~There must be one drill each quarter for those disasters identified in the HVA. These drills should be rotated to address the types of events most likely to occur based on the HVA.~~

~~4. Annual drill of Continuity of Operations Plan for the agency.~~

~~On an annual basis (on or before the date of the previous drill), you must conduct a drill for your Continuity of Operations Plan. You should conduct this drill to test each level of the plan including activating essential~~

~~staff, movement of vital records, and activating agreement with alternate site location. This drill should be documented and kept on file for review.~~

~~PLEASE SEE ATTACHMENT B FOR FURTHER GUIDANCE ON DRILLS AND MONITORING OF DRILLS~~

~~Rule 13.9.F All supervised living, residential treatment programs, and/or Crisis Stabilization Units must maintain current emergency/disaster preparedness supplies to support individuals receiving services and staff for a minimum of seventy-two (72) hours post event. At a minimum, these supplies must include the following:~~

1. **~~Non-perishable foods~~**
2. **~~Manual can opener~~**
3. **~~Water~~**
4. **~~Flashlights and batteries~~**
5. **~~Plastic sheeting and duct tape~~**
6. **~~Battery powered radio~~**
7. **~~Personal hygiene items.~~**

~~For supervised living programs and residential substance abuse treatment programs, you must keep on site at a minimum the items above. Any other items that are viewed as necessary should also be kept on site in the event of an emergency/disaster. These will be viewed on site by the site visit team. Please be sure to monitor expiration dates as expired products will be viewed as missing by the site visit team. You must list all items that you plan to keep on site for such events in the Emergency/Disaster Response Plan. It is up to the program to determine the right amount to provide these items for the clients on site.~~

~~Rule 13.9.G All supervised living, residential treatment programs, and/or Crisis Stabilization Units must have policies and procedures that can be implemented in the event of an emergency that ensure medication, prescription and nonprescription, based on the needs of the individuals in the program and guidance of appropriate medical staff is available for up to seventy-two (72) hours post-event.~~

~~Each program must have policies and procedures that state they will not only have seventy-two (72) hour supply of all prescription and non-prescription medication for each resident, but they must also have appropriate staff available to administer those medications.~~

~~ATTACHMENT A – Hazard Vulnerability Analysis (HVA)~~

- ~~An HVA is conducted to determine the risks associated with probable or possible disasters or events.~~
- ~~An HVA identifies the events most likely to affect your organization and the probable impact if they do occur~~
- ~~Depending on the evaluated level of preparedness, the facility must take necessary steps to ensure they are prepared to meet the challenges presented by the hazards~~

~~There are Four Areas of Concern: Natural, Technological, Human, and Hazmat Events~~

~~These should be broken out into each individual type of event (i.e. tornado, fire, etc.)~~

~~Items to address for each event type:~~

- ~~Probability~~
  - ~~What is the known risk this will happen~~
    - ~~Low – Rare~~
    - ~~Moderate – Unusual~~
    - ~~High – High Potential or Have Experienced~~
  - ~~Use of historical data about previous events can help predict the likelihood~~

- ~~Response~~
  - ~~How long would it take to have an on-scene response~~
  - ~~How big will that response be~~
  - ~~Historical evaluation of response success~~

- ~~Human Impact~~
  - ~~Potential for staff death or injury~~
  - ~~Potential for patient death or injury~~

- ~~Property Impact~~
  - ~~Cost and time to replace/repair~~
  - ~~Cost to set up temporary replacement~~
  - ~~Time to recover~~

- ~~Business Impact~~
  - ~~Business interruption~~
  - ~~Employees and/or patients unable to report to work~~
  - ~~Interruption of critical supplies~~
  - ~~Financial impact/burden~~

- ~~Preparedness~~
  - ~~Status of current plans (how ready are you for each type of event)~~
  - ~~Frequency of drills~~
  - ~~Availability of alternate sources for critical supplies/services~~

- ~~Internal Resources~~
  - ~~Types and amount of supplies on hand and will they meet the need~~
  - ~~Staff availability~~

- ~~External Resources~~
  - ~~Types of agreements with community agencies~~
  - ~~Coordination with local and state agencies~~
  - ~~Coordination with nearby health care facilities~~
  - ~~Coordination with treatment specific facilities~~
  - ~~Community resources~~

~~ATTACHEMENT B – Disaster, Fire, and COOP Drill Guidance~~

~~Disaster, Fire, and COOP Drills for all Programs~~

~~Purpose~~

~~Each provider certified by the DMH must maintain an emergency/disaster response plan for each service location/site for responding to natural disasters and manmade disasters (fires, bomb threats, utility failures and other threatening situation such as workplace violence). Providers must maintain a Continuity of Operations Plan (COOP) describing how operations will continue in the event of a natural or manmade disaster. Each location/site must document proof of implementation of these written plans as evidenced by written reports of scheduled and conducted fire, disaster, and COOP drills.~~

~~Timeline~~

- ~~Disaster drills must be conducted and documented at least quarterly.~~
    - ~~Disaster drills must rotate the nature of the event for the drill based on each facility and program's emergency/disaster plan.~~

- ~~Fire drills must be conducted and documented at least monthly for all supervised living and/or residential programs and quarterly for all day programs.~~
    - ~~Fire drills for residential programs must be conducted on a rotating schedule across all three shift schedules.~~

- ~~COOP drills must be conducted and documented at least annually.~~

~~General Information~~

~~Each provider is responsible for developing report formats that will document all aspects of each type of drill in order to ensure the safety of all persons involved in the drill. Elements to be recorded in each drill report include but are not limited to:~~

- ~~Name and location of the program~~
- ~~Type/nature of the drill~~
- ~~Date of the drill~~
- ~~Time the drill began~~
- ~~Time the drill ended~~
- ~~Nature of the event (tornado, bomb, hurricane, other) for a disaster drill~~
- ~~Number of participants~~
- ~~Names of staff participating~~
- ~~Assessment of the drill that addresses elements of the emergency/disaster or COOP plan as well as the behavior of those participating in the drill~~
- ~~Signature and title of the staff person completing the report~~

~~Providers are welcome to contact the Office of Incident Management at 601-359-6652 for technical assistance in the development of drill reports.~~

~~Disaster, Fire, and COOP Drills for all Programs~~

~~Purpose~~

~~Each provider certified by the DMH must maintain an emergency/disaster response plan for each service location/site for responding to natural disasters and manmade disasters (fires, bomb threats, utility failures and other threatening situations such as workplace violence). Providers must maintain a Continuity of Operations Plan (COOP) describing how operations will continue in the event of a natural or manmade disaster. Each location/site must document proof of implementation of these written plans as evidenced by written reports of scheduled and conducted fire, disaster, and COOP drills.~~

~~Timeline~~

- ~~Disaster drills must be conducted and documented at least quarterly.~~
  - ~~Disaster drills must rotate the nature of the event for the drill based on each facility and program's emergency/disaster plan.~~

- ~~Fire drills must be conducted and documented at least monthly for all supervised living and/or residential programs and quarterly for all day programs.~~
  - ~~Fire drills for supervised living residential treatment service must be conducted on a rotating schedule across all three shift schedules.~~

- ~~COOP drills must be conducted and documented at least annually.~~

~~General Information~~

~~Each provider is responsible for developing a report that will document all aspects of each type of drill in order to ensure the safety of all persons involved in the drill. Elements to be recorded in each drill report include but are not limited to:~~

- ~~Name and location of the program~~
- ~~Type/nature of the drill~~
- ~~Date of the drill~~
- ~~Time the drill began~~
- ~~Time the drill ended~~
- ~~Nature of the event (tornado, bomb, hurricane, other) for a disaster drill – must rotate quarterly based on potential hazards~~
- ~~Number of participants~~
- ~~Names of staff participating~~
- ~~Assessment of the drill that addresses elements of the emergency/disaster or COOP plan as well as the behavior of those participating in the drill~~
- ~~Signature and title of the staff person completing the report~~

~~Providers are welcome to contact the Division of Disaster Preparedness and Response at 601-359-1288 for technical assistance in the development of drill reports.~~

~~**Fire and Disaster Drill Report Form**~~	~~**Program Name**~~ ______ ~~**Date of Drill**~~ ______ ~~**Time of Drill (am/pm)**~~ ______

~~**Type of Drill :**~~

☐ ~~**Fire** (quarterly for day programs, monthly for residential programs)~~

☐ ~~**Disaster** (quarterly for all programs)~~ ~~**Type of Disaster:**~~ ______
~~(Disaster type must rotate each quarter through all applicable disasters)~~

☐ ~~**COOP** (annual for all programs)~~

~~**Exact Start Time of Drill:**~~ ______ ~~**Exact End Time of Drill:**~~ ______

~~**Amount of Time to Complete Drill :**~~ ______

~~**Number of Participants (not staff) :**~~ ______

~~**Staff Participating in Drill :**~~ ______ ______

______ ______

______ ______

______ ______

______ ______

~~**Written assessment of general performance on the drill :**~~
~~(please be specific about actions that took place during the drill)~~

~~**Signature of Staff Member Preparing Report :**~~

~~Required Plan of Compliance~~

~~Purpose~~
~~All DMH Certified Providers must submit a Plan of Compliance in response to findings included in a DMH Written Report of Findings. This template must be utilized by providers.~~

~~Timeline~~
~~The plan must be completed within the timeframe stated in the DMH Written Report of Findings.~~

~~Finding~~
~~Reference the DMH Operational Standard included in the DMH Written Report of Findings.~~

~~Program/Service~~
~~Reference the program or service (if there is not a specific physical location for the program) included in the DMH Written Report of Findings.~~

~~Corrective Action Steps~~
~~Outline the action steps the provider will put in place to correct the findings. Do not include justification. A request for a waiver of a DMH Operational Standard is not considered a corrective action step.~~

~~Time Line~~
~~Include the implementation date and estimated date of completion for each corrective action.~~

~~Deficiencies related to Chapters 13, 32 and/or 34 of the DMH Operational Standards must be corrected within 30 days of the date of this letter.~~

~~Plan for Continued Compliance~~
~~Outline the plan for how the agency will continue to comply with DMH Operational Standards and the identified correction action plan(s).~~

~~Required Plan of Compliance~~

~~Plan of Compliance~~	
~~Please complete **all** requested information and mail completed form and supporting documentation to:~~ ***~~Division of Certification~~*** ***~~MS Department of Mental Health~~*** ***~~239 North Lamar Street, Suite 1101~~*** ***~~Jackson, MS 39201~~***	~~In lieu of mailing the form, you may e-mail the completed electronic form and supporting documentation to the Division of Certification. For contact information call #601-359-1288.~~

~~Provider Name:~~		**~~Phone:~~**	
~~Provider Contact Person for follow-up:~~		**~~Fax:~~**	
		~~Email:~~	

~~Finding (DMH Standard Number)~~	~~Program/Service/ Record~~	~~Corrective Action(s)~~	~~Time Line~~	~~Plan for Continued Compliance~~
			~~Implementation Date:~~	
			~~Projected Completion Date:~~	
			~~Implementation Date:~~	
			~~Projected Completion Date:~~	
			~~Implementation Date:~~	
			~~Projected Completion Date:~~	
			~~Implementation Date:~~	
			~~Projected Completion Date:~~	

~~Staff Verification of Training on Suspected Abuse or Neglect Reporting Requirements~~

~~Purpose~~

~~All provider staff must be informed of and trained on the procedures for reporting suspicions of abuse or neglect in accordance with state reporting laws to include but not limited to the Vulnerable Persons Act and Child Abuse or Neglect Reporting requirements.~~

~~Time Line~~

~~All provider staff must be informed of and trained on the procedures for reporting suspicions of abuse or neglect of individuals receiving services in accordance with state reporting laws.~~

~~Individuals acknowledge receipt of the information and training during General Orientation before service delivery. A copy of the verification must be maintained in the staff personnel record.~~

~~Verification form is updated if training is repeated or new training is provided.~~

~~Staff Verification of Training on Suspected Abuse or Neglect Reporting Requirements~~

~~I acknowledge that I have been informed of and trained on the procedures for reporting suspicions of abuse or neglect in accordance with state reporting laws to include but not limited to the Vulnerable Persons Act and Child Abuse or Neglect Reporting requirements.~~

~~I understand that I have a personal responsibility to report suspicions of abuse or neglect in accordance with state reporting laws.~~

~~Staff Signature/ Position or Credentials~~	~~Witness/ Position or Credentials~~	~~Date~~